AMA/Specialty Society RVS Update Committee
Hyatt Regency Coconut Point, Bonita Springs, FL
January 11-14, 2017

Meeting Minutes

I. Welcome and Call to Order

Doctor Peter Smith called the meeting to order on Thursday, January 12, 2017 at 3:00 p.m. The following RUC Members were in attendance:

Peter K. Smith, MD	Amr Abouleish, MD, MBA*
Margie C. Andreae, MD	Allan Anderson, MD*
Michael D. Bishop, MD	Gregory L. Barkley, MD*
James Blankenship, MD	Eileen Brewer, MD*
Dale Blasier, MD	Joseph Cleveland, MD*
Ronald Burd, MD	William D. Donovan, MD, MPH*
Jimmy Clark, MD	Jeffrey P. Edelstein, MD*
Scott Collins, MD	William E. Fox, MD, FACP*
Gregory DeMeo, MD	William F. Gee, MD*
Verdi. J DiSesa, MD, MBA	Michael J. Gerardi, MD, FACEP*
James L. Gajewski, MD	Peter Hollmann, MD*
David F. Hitzeman, DO	Gwenn V. Jackson, MD*
Katharine Krol, MD	John Lanza, MD*
Timothy Laing, MD	Mollie MacCormack, MD, FAAD*
Walter Larimore, MD	Eileen Moynihan, MD*
Alan Lazaroff, MD	Daniel J. Nagle, MD*
M. Douglas Leahy, MD, MACP	Dee Adams Nikjeh, PhD, CCP-SLP*
Scott Manaker, MD, PhD	M. Eugene Sherman, MD*
Bradley Marple, MD	Samuel Silver, MD, PhD*
Guy Orangio, MD	Holly Stanley, MD*
Julia M. Pillsbury, DO, FAAP	Robert J. Stomel, DO*
Gregory Przybylski, MD	Michael J. Sutherland, MD, FACS*
Marc Raphaelson, MD	Thomas J. Weida, MD*
Christopher K. Senkowski, MD, FACS	David S. Wilkinson, MD, PhD*
Ezequiel Silva III, MD	
Norman Smith, MD	
Stanley W. Stead, MD, MBA	
James C. Waldorf, MD	
Jane White, PhD, RD, FADA	
Jennifer L. Wiler, MD, MBA	
George Williams, MD	*Alternate

II. Chair's Report

- Doctor Smith welcomed everyone to the RUC Meeting.

- Doctor Smith welcomed the Centers for Medicare & Medicaid Services (CMS) staff and deferred introducing the CMS representatives to Doctor Hambrick during her report.

- Doctor Smith welcomed the following Contractor Medical Director:
  - Charles Haley, MD, MS

- Doctor Smith welcomed the following Member of the CPT Editorial Panel:
  - Kathy Krol, MD –CPT Panel RUC Member

- Doctor Smith recognized departing RUC members:
  - James Gajewski, MD
  - Guy Orangio, MD
  - Jane White, PhD, RD, FADA

- Doctor Smith welcomed new RUC member:
  - Bradley Marple, MD – AAO-HNS

- Doctor Smith welcomed the following Observers:
  - Patrice A. Harris, MD, MA – Chair, AMA Board of Trustees
  - Alice Coombs, MD – MedPAC/New England Medical Association
  - David Chan, MD – Stanford Health Policy. Doctor Chan is preparing a manuscript for submission to NEJM based on RUC activities.

- Doctor Smith explained the following RUC established thresholds for the number of survey responses required:
  - Codes with ≥1 million Medicare Claims = **75 respondents**
  - Codes with Medicare Claims from 100,000 to 999,999 = **50 respondents**
  - Codes with <100,000 Medicare = **30 respondents**
  - Surveys below the established thresholds for services with Medicare claims of 100,000 or greater will be reviewed as interim and specialty societies will need to resurvey for the next meeting.

- Doctor Smith laid out the following guidelines related to confidentiality:
  - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement at the registration desk.)
  - This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.

- Doctor Smith shared the following procedural rules for RUC members:
  - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes.
  - RUC members or alternates sitting at the table may not present or debate for their society.
  - RUC members or alternates should not attend Facilitations in which your specialty is involved (if you were assigned to that facilitation switch with another RUC member).
  - Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.

- Doctor Smith laid out the following procedural guidelines related to specialty society staff/consultants:
  - Specialty Society Staff or Consultants should not present/speak to issues at the RUC Subcommittee, Workgroup or Facilitation meetings – other than providing a point of clarification.

- Doctor Smith laid out the following procedural guidelines related to commenting specialty societies:
    - In October 2013, the RUC determined which members may be "conflicted" to speak to an issue before the RUC:
        1) a specialty surveyed (LOI=1) or
        2) a specialty submitted written comments (LOI=2).

        RUC members from these specialties are not assigned to review those tabs.
    - The RUC also recommended that the RUC Chair welcome the RUC Advisor for any specialty society that submitted written comments (LOI=2), to come to the table to verbally address their written comments. It is the discretion of that society if they wish to sit at the table and provide further verbal comments.

- Doctor Smith shared the following procedural guidelines related to voting:
    - RUC votes are published annually on the AMA RBRVS website each November for the previous CPT cycle.
    - The RUC votes on every work RVU, including facilitation reports.
    - If members are going to abstain from voting because of a conflict or otherwise, please notify AMA staff so we may account for all 28 votes.
    - Please share voting remotes with your alternate if you step away from the table to ensure 28 votes.

- Doctor Smith announced:
    - That all meetings are recorded for AMA staff to accurately summarize recommendations to CMS.
    - There is currently not a nominee for the rotating Internal Medicine seat. There was a nominee who had to withdraw due to time management conflicts. Anticipate hearing of a nominee by noon tomorrow so can vote on Saturday morning.

- Doctor Smith presented the first-ever "Best RUC Reviewer" Award. This award was created to recognize that the value of the meeting proceeding expeditiously and accurately is, to a large extent, dependent on the work that is done prior to the meeting. Doctor Smith and the staff review all the comments submitted prior to the meeting and decided to provide a prize for the best two commenters (the best – not the most). The award was presented to the following RUC members:
    - Scott Collins, MD
    - Zeke Silva, MD

  Doctors Collins and Silva were awarded this special recognition for their extensive comments provided on recommendations for the January 2017 RUC meeting. For their efforts, each is awarded one "get out of reviewing a RUC tab" for the April 2017 RUC meeting. The award must be redeemed within 24 hours of the assignments.

III. Director's Report (Tab 1)

Sherry L. Smith, MS, CPA, Director of Physician Payment Policy and Systems, AMA provided the following Director's Report:

- Reminder that the AMA server is going to be updated this weekend. There will be no access to the RUC Collaboration site from Friday at 5:00 PM to Saturday at 8:00 AM EST. Please make sure you have documents downloaded and provide staff with any necessary uploads by noon on Friday.
- Introduced our two new RUC staff: Jorge Belmonte and Rebecca Gierhahn.

IV. Approval of Minutes from October 2016 RUC Meeting (Tab 2)

- The RUC approved the October 2016 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update (Tab 3)

Doctor Kathy Krol provided the following update of the CPT Editorial Panel:

- The Panel has not met since the last RUC meeting in October. At its September meeting, the Panel reviewed 103 issues and about 22 of the tabs are on the RUC agenda for this meeting.
- The Panel postponed the following issues at its September meeting, and all three will be on the Agenda for consideration at the upcoming February 2017 meeting: Skin Biopsy, Pattern Electroretinography and Neurostimulator Services. While these three issues were sent from RUC and were scheduled to be included in the 2018 cycle, the Panel had to postpone each of these pending further work, pushing all three into the 2019 cycle.
- Update on Structural Allograft – the Panel accepted three codes to report osteoarticular, hemicortical, and intercalary allografts at the September 2016 meeting, but upon review of the Panel action memo, the societies determined that they had submitted an incomplete application without reference to the expectation for add-on status for these codes. The applicants have requested postponement of publication of these codes pending Panel consideration of the appropriate code structure. An application has been submitted for the February 2017 Panel meeting.
- Update on Psychological and Neurospsychological Testing – the Panel accepted seven codes to differentiate technician administration of psychological testing and neuropsychological testing from physician/psychologist administration and assessment testing. However, the Panel received a joint letter from the seven specialty societies involved to the CPT Editorial Panel and the RUC regarding the Psychological and Neuropsychological Evaluation and Testing code family. Based on their experience with the RUC survey process, they are seeking to refer this code family back to the CPT Editorial Panel as well as removing it from the January 2017 RUC meeting agenda. This issue will be placed on the February 2017 Executive Committee agenda.
- The next Panel meeting will take place on February 9-11, 2017 in New Orleans. The Panel will consider roughly 56 agenda items. There are a number of RUC referrals on the agenda that include about 14 codes.
- The February 2017 meeting will also include the Annual CPT/HCPAC Advisory Committee meeting. Several topics that may be of interest include:
    - CPT Strategic Plan
    - Code Set Maintenance/Standardization of Nomenclature/CPT Dictionary
    - Appropriate Use Criteria – MACRA-APM's Potential Modifier -Identification of coding solutions, given APMs. The Panel will also address one tab for a proposed prospective comprehensive bundled payment model. The Panel is beginning to contemplate requirements for this type of coding proposal.
    - Code Set Options for External Staff/Equipment Report – This is a topic that came up at both the September 2016 CPT meeting and the October 2016 RUC meeting, and involves coding/payment questions for services that are sometimes performed by non-facility/non-employed staff personnel. The discussion will be directed to potential coding solutions for emerging office/facility service patterns.

- Doctor Walt Larimore will attend the February meeting as the RUC representative to the Panel, and the Panel continues to welcome any RUC members who wish to attend.

- The new CPT Proprietary Laboratory Analyses (PLA) website portal opened on October 1, 2016. The Panel approved three PLA codes that have been published on the AMA corporate website. In the next round of reviews, they will be looking at roughly 5-6 PLA applications. The application closing date for this round of codes is January 12, 2017.
- The June 1-3, 2017, Panel meeting will take place in Boston, MA. The submission deadline for code change applications for that meeting is March 1, 2017.

VI. Centers for Medicare and Medicaid Services Update (Informational)

Doctor Edith Hambrick, CMS Medical Officer, provided the report of the Centers for Medicare & Medicaid Services (CMS):

- Introduced staff from CMS attending this meeting:
  - Isadora Gil, PhD – Health Insurance Specialist
  - Karen Nakano, MD – CMS Medical Officer
  - Michael Soracoe – Research Analyst

- Addressed the post-election transition that will occur a week from now. After confirmation hearings, the HHS Secretary-designate, Rep. Tom Price, MD, and the CMS Administrator-designate, Seema Verma, MPH, will be in office.

- The Physicians' Payment Schedule Final Rule will be released on or about November 1st. Please come in and talk to CMS about any issues regarding codes or policy, especially anything related to the CY2017 Final Rule, recognizing that there will be a new team in place.

VII. Contractor Medical Director Update (Informational)

Doctor Charles E. Haley, Medicare Contractor Medical Director, Noridian, provided the contractor medical director update:

- Jurisdiction J (GA, AL, TN) was re-bid, and the bids are currently being considered by CMS. The new awardee will be announced this spring. During 2017, expect one or two more AB-MAC contracts to be re-bid.

- Modifier J-W: CMS has required that drug wastage be reported on a separate line with the J-W modifier. Noted that there are many exceptions to this rule.

VIII. Washington Update (Informational)

Sharon McIlrath, Assistant Director Federal Affairs, AMA, provided the RUC with the following information regarding the AMA's advocacy efforts:

- The SGR repeal bill is entitled The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Ms. McIlrath addressed the question as to whether MACRA will go away given the election. This is not likely given its bipartisan support.

- MACRA Basics:
  - MACRA was designed to offer physicians a choice between two payment pathways:
    - A modified fee-for-service model (MIPS)
    - New payment models that reduce costs of care and/or support high-value services not typically covered under the Medicare fee schedule (APMs)

  - In the beginning, most are expected to participate in MIPS
  - CMS named the physician payment system created by MACRA the Quality Payment Program (QPP)
- Merit-based Incentive Payment System (MIPS)
  - MIPS components include:
    - Quality Reporting (was PQRS)
    - Advancing Care Information (was Meaningful Use)
    - Cost (was Value-based Modifier)
    - Improvement Activities
  - MIPS component weights (when fully transitioned in 2019):
    - 30% Quality
    - 25% ACI
    - 30% Cost
    - 15% Improvement Activities
  - Calculating payment adjustments
  - Pick Your Pace:2017 transitional performance reporting options
    - MIPS Testing
    - Partial MIPS reporting
    - Full MIPS reporting
    - Advanced APM participation
    - The only physicians who will experience negative payment adjustments (-4%) in 2019 are those who report no data in 2017
- Alternative Payment Models (APMs)
  - APMs participation options as outlined by CMS
    - "Advanced" APMs--term established by CMS; these have greatest risks and offer potential for greatest rewards
    - Qualified Medical Homes have different risk structure but otherwise treated as Advanced APMs
    - MIPS APMs receive favorable MIPS scoring
    - Physician-focused APMs are under development
- AMA Advocacy:
  - Our overarching aims in shaping regulations
    - Choice, flexibility, simplicity, feasibility
  - Six internal measures for judging success
    - Start date and reporting period
    - Simplify the MIPS program
    - Modify the MIPS performance threshold
    - Increase the low volume threshold for MIPS reporting
    - More relief for small and rural practices
    - Expand opportunities for APMs
  - Cannot overstate contribution of constructive CMS approach
  - What physicians can do to prepare:
    - AMA Understanding Medicare Reform home page www.ama-assn.org/MACRA
    - AMA MACRA checklist available on AMA website
    - AMA Payment Model Evaluator tool
    - CMS measure selection tool www.qpp.cms.gov
    - Completion of select STEPS Forward™ modules meets eligibility criteria for Improvement Activity category credit www.stepsforward.org

IX. Relative Value Recommendations for *CPT 2018:*

Anesthesia for GI Procedures (Tab 4)
Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)

In the Final Rule for 2016, CMS stated that the anesthesia procedure codes 00740 *Anesthesia for procedure on gastrointestinal tract using an endoscope* and 00810 *Anesthesia for procedure on lower intestine using an endoscope* are used for anesthesia furnished in conjunction with lower GI procedures. In reviewing Medicare claims data, CMS noted that a separate anesthesia service is now reported more than 50 percent of the time when several types of colonoscopy procedures are reported. Given the significant change in the relative frequency with which anesthesia codes are reported with colonoscopy services, CMS believes the base units of the anesthesia services should be reexamined. Therefore, CMS identified CPT codes 00740 and 00810 as potentially misvalued.

The RUC reviewed CPT codes 00740 and 00810 in January 2016 and recommended:
1. An interim base unit of 5 for code 00740 and 00810 and notes the comparison to the RUC recommended values for moderate sedation, 99156 and 99157, results in a work RVU equivalent that is only slightly higher than moderate sedation service of the same number of minutes.
2. Referral to the Research Subcommittee for review of the vignettes and to develop a method on how to review the survey data to value these services. The RUC recommended that the specialty societies revise the vignette for the typical patient receiving anesthesia for an EGD for 00740 and for a patient receiving anesthesia for a colonoscopy (45378) for 00810.
3. Resurvey 00740 and 00810 for the April 2016 RUC meeting.

In April 2016, an Ad Hoc Anesthesia Workgroup was formed to discuss the issues surrounding these services. The specialty society requested and the Workgroup agreed that CPT codes 00740 and 00810 are too broad in the range of endoscopic procedures covered under each code and should be referred to the CPT Editorial Panel September 2016 meeting to request a new family of anesthesia codes to describe anesthesia for GI endoscopic procedures. The revised codes will specifically identify those patients undergoing both upper and lower gastrointestinal endoscopic procedures. The RUC recommends CPT codes 00740 and 00810 be referred to CPT to better define these services. The Anesthesia Workgroup also recommended an educational presentation be provided to the RUC on the existing survey and valuation process for anesthesia services since it has not been validated or used for a survey since 2007, including a specific example of how the data from a survey are used to value an anesthesia service.

In September 2016 the CPT Editorial Panel deleted two codes 00740 and 00810 and created two new codes for upper, two new codes for lower and one new code for upper and lower endoscopic procedures.

In January 2017, ASA provided an overview of the anesthesia payment system. The three main points discussed were that payment for anesthesia services are based on a different relative system, time is not a factor in establishing base unit value and payments for anesthesia services use a different formula.

Payments for anesthesia services are based on a different relative system.
The rank order of anesthesia codes is independent of the intra-service times for the anesthesia procedures (or the underlying surgical procedures). Base units range from a low of 3 units to a high of 30 base units with the exception of three add-on codes. Noting that anesthesia base and time units include a combination of work, practice expense and professional liability. For 2017, the percentage of the anesthesia units allocated to physician work is 78.6%

Time is not a factor in establishing base unit value.
Unlike other services valued under RBRVS, the intra-service time is not a factor that is considered when determining a base unit value. The base unit value reflects three major components of the anesthesia service: (1) the intensity and complexity of the intra-service anesthesia care (but not the length of time of that care); (2) the amount of pre-anesthesia service work (pre-anesthesia evaluation and preparation of equipment and medications); and (3) the amount of post-anesthesia service. Hence, two anesthesia CPT codes can have the same or similar base unit values but very different intra-service anesthesia times. The similarity of base unit values indicates that the two codes have similar intra-service intensity/complexity, pre-anesthesia work, and post-anesthesia work. Differences in intra-service anesthesia times are accounted for by reporting the actual time for each procedure, not through differences in base unit values. Similarly, two anesthesia CPT codes may have very different base unit values but similar intra-services times.

Payments for anesthesia services use a different formula.
Anesthesia services are valued based on the base unit value and time. For each anesthesia claim, time is separately calculated and is submitted in actual minutes. CMS converts reported minutes into time units when determining payment. Per CMS, 15 minutes equal 1 time unit. To determine the total number of time units, the reported number of minutes is divided by 15 and taken out to one decimal place. Although CMS uses a 15-minute time unit, CMS does not pay in 15-minute increments, but pays by the minute (divides minutes by 15 to determine the number of units to 1 decimal place). [Anesthesia Base Units + Time Units] x Anesthesia Conversion Factor. The 2017 Anesthesia Conversion Factor is $22.0454.

00731 ***Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified***
The RUC reviewed the survey results from 86 anesthesiologists and determined that the median base unit of 5 appropriately accounts for the work required to administer anesthesia for these services. This new code is projected to represent about 89% of the utilization of the old 00740 service. The specialty society noted that 78% of the respondents felt that the vignette was typical. The survey respondents indicated that the intensity and complexity measures for 00731 are equal or slightly more than those for the key reference service 00320 *Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age 1 year or older* (base unit = 6), which supports the base unit recommendation. The specialty society also compared the surveyed service 25 minutes of intra-service (induction period and post-induction period) to the moderate sedation codes as this is a clinically comparable service to anesthesia (see table below). The specialty society indicated that anesthesia services have higher intensity and work than moderate sedation services. Therefore, choosing the median base unit of 5 appropriately values this service. If the 25th percentile 4 base units value is used, then the anesthesia service would be valued less than the moderate sedation services (2.76 vs. 2.90) and would cause a rank order anomaly. The recommended median base unit value maintains relativity of values across the entire fee schedule. Lastly, the specialty society indicated and the RUC agreed that a base unit value of 5 for 00731 is in the appropriate rank order compared to what is recommended for 00732. **The RUC recommends a base unit of 5 for CPT code 00731.**

Conversion of Anesthesia Units for Median Intra-service Time to Work RVUs (wRVUs)

00731, Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified					
Base Unit	**Anesthesia Time***	**Time Units****	**Total Anesthesia Units**	**wAnesthesia Units*****	**wRVU Equivalent**
3	25	1.7	4.7	3.7	2.27
4	25	1.7	5.7	4.5	2.76
5	**25**	**1.7**	**6.7**	**5.2**	**3.26**
6	25	1.7	7.7	6.0	3.75
7	25	1.7	8.7	6.8	4.18

*Median survey for induction and post-induction time which equals intra-service time for anesthesia care
** Time Units = anesthesia time/15 to one decimal place
*** wAnesthesia Units = Total Anesthesia Units * 0.786

The moderate sedation service median intra-service times are shown in the following table:

Moderate Sedation Services wRVUs

Moderate Sedation for 25 min over age 5, different physician	**wRVUs**
99156 x 1	1.65
99157 x 1	1.25
Total	**2.90**

00732 ***Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)***
The RUC reviewed the survey results from 63 anesthesiologists and determined that the median base unit of 6 appropriately accounts for the work required to administer anesthesia for these services. This new code is projected to represent about 11% of the utilization of the old 00740 service. The specialty society noted that 81% of the respondents felt that the vignette was typical. The survey respondents indicated that the intensity and complexity measures for 00732 are equal or slightly more than those for the top two key reference services 00320 *Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age 1 year or older* (base unit = 6) and 00840 *Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified* (base unit= 6), which supports the base unit recommendation. The specialty society also compared the surveyed service 65 minutes of intra-service (induction period and post-induction period) to the moderate sedation codes as this is a clinically comparable service to anesthesia (see table below). Recommending the median base units of 6 values this anesthesia service less than the moderate sedation services (4.98 to 5.40 work RVUs). However, recommending the 75th percentile base unit of 7 would not maintain the relativity compared to the key reference services and would not maintain the proper rank order with 00731. The specialty society indicated that the post-induction period procedure anesthesia (PIPPA) intensity is the highest for this service compared to the other four anesthesia services that have a base unit of 6. The specialty societies indicated that CPT code 00732 is the most intense compared to those services and is therefore valued appropriately at 6 base units. The RUC agreed that the anesthesia work for ERCP is more intense than 00731. **The RUC recommends a base unit of 6 for CPT code 00732.**

Conversion of Anesthesia Units for Median Intra-service Time to Work RVUs (wRVUs)

00732, Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)

Base Unit	Anesthesia Time*	Time Units**	Total Anesthesia Units	wAnesthesia Units***	wRVU Equivalent
5	65	4.3	9.3	7.3	4.48
6	**65**	**4.3**	**10.3**	**8.1**	**4.98**
7	65	4.3	11.3	8.9	5.47
8	65	4.3	12.3	9.7	5.96

*Median survey for induction and post-induction time which equals intra-service time for anesthesia care
** Time Units = anesthesia time/15 to one decimal place
*** wAnesthesia Units = Total Anesthesia Units * 0.786
**** $ Paid CMS = wAnesthesia Units * Anesthesia CF

The moderate sedation service median intra-service times are shown in the following table:

Moderate Sedation Services wRVUs

Moderate Sedation for 65 min over age 5, different physician	wRVUs
99156 x 1	1.65
99157 x 3	3.75
Total	**5.40**

00811 ***Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified***
The RUC reviewed the survey results from 53 anesthesiologists and determined that the survey 25th percentile base unit of 4 appropriately accounts for the work required to administer anesthesia for these services. The RUC noted that this service will typically be reported 1,205,000 times for Medicare patients and therefore did not meet the threshold of 75 surveys. The recommend value for this service will be interim and the specialty society will need to resurvey for the April 2017 RUC meeting.

This new code represents about 70% of the Medicare utilization of the old 00810 service. The specialty society noted that 87% of the respondents felt that the vignette was typical. The survey respondents indicated that the intensity and complexity measures for 00811 are equal or slightly more than those for the top two key reference services 00914 *Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of prostate* (base unit = 5) and 00830 *Anesthesia for hernia repairs in lower abdomen; not otherwise specified* (base unit = 4), which supports the base unit recommendation. The RUC noted that the overall intensity for the lower GI anesthesia services is less than the upper GI services 00731 and 00732. Therefore, the survey 25th percentile and median base unit of 4 is more appropriate than the initial specialty society recommendation of 5 base units, the survey 75% percentile. **The RUC recommends an interim base unit of 4 for CPT code 00811. The specialty society will resurvey and present for April 2017.**

00812 ***Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy***
The RUC reviewed the survey results from 47 anesthesiologists and determined that the survey median base unit of 4 appropriately accounts for the work required to administer anesthesia for

these services. The RUC noted that this service will typically be reported 515,000 and therefore did not meet the threshold of 50 surveys. The recommend value for this service will be interim and the specialty society will need to resurvey for the April 2017 RUC meeting.

This new code represents about 30% of the Medicare utilization of the old 00810 service. The specialty society noted that 90% of the respondents felt that the vignette was typical. The survey respondents indicated that the intensity and complexity measures for 00812 are slightly less intense than those for the top two key reference services 00910 *Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified* (base unit = 3) and 00914 *Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of prostate* (base unit = 5), which supports the base unit recommendation. Based on the RUC reviewer comments, screening colonoscopies typically may be less intense than the diagnostic or procedural colonoscopy, therefore are recommending 4 base units. Additionally, the survey respondents indicated that the PIPPA for 00812 is higher/more intense for this service than the other two anesthesia services with a base unit of 4, thus supporting the value. The RUC agreed that this service should be valued lower than the anesthesia for upper GI services CPT codes 00731 and 00732 and thus is valued appropriately. **The RUC recommends an interim base unit of 4 for CPT code 00812. The specialty society will resurvey and present for April 2017.**

00813 ***Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum***
The RUC reviewed the survey results from 47 anesthesiologists and determined that the survey median base unit of 5 appropriately accounts for the work required to administer anesthesia for these services. This new code represents less than 1% of the old 00810 service. The specialty society noted that 85% of the respondents felt that the vignette was typical. The survey respondents indicated that the intensity and complexity measures for 00813 are equal or slightly more than those for the top two key reference services 00320 *Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age 1 year or older* (base unit = 6) and 00830 *Anesthesia for hernia repairs in lower abdomen; not otherwise specified* (base unit = 4), which supports the base unit recommendation. The RUC noted that this service includes anesthesia for the combined upper and lower GI procedures, codes 00731 and 00811. Therefore, a base unit of 5 places this service in the proper rank order with this family of services. **The RUC recommends a base unit of 5 for CPT code 00813.**

Practice Expense
The specialty society requested the standard 8 minutes of colorectal service time as is consistent for all anesthesia codes. The RUC recommends the direct practice expense inputs as submitted by the specialty society.

Work Neutrality:
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

<u>Muscle Flap (Tab 5)</u>
Mark Villa, MD (ASPS); Charles Mabry, MD, FACS (ACS)

CPT Codes 15732 and 15736 were identified via the High Level E/M in Global Period screen. The RUC identified that a 99214 office visit is included for 15732 and 15736 but not included in the other codes in this family.

In April 2016 the RUC reviewed code 15732 and the specialty society explained that just like the three previous surveys for this procedure, the results indicate the typical patient will have

inpatient status (72%) and the typical length of stay will be four days. As in the past, this conflicts with the Medicare utilization data that shows the primary place of service as outpatient hospital. Therefore, the specialty society determined that the code needs to be referred to the CPT Editorial Panel to better differentiate and describe the work of large flaps performed on patients with head and neck cancer who will have inpatient status and be similar to the other procedures in this family. This is in contrast to smaller flaps that may be accomplished in an office or outpatient setting and would be best coded by the adjacent tissue transfer codes. In addition, during the discussion, CMS requested that CPT code 15731 be added to the family of codes for the subsequent RUC review. The RUC recommended referral of CPT code 15732 to the CPT Editorial Panel. In September 2016, the CPT Editorial Panel deleted code 15732 and created two codes to specify the types of flaps associated with head and neck defect repairs. Codes 15731, 15734, 15736 and 15738 were added as part of this family of services for review. CPT codes 15734, 15736 and 15738 were recently reviewed at the April 2016 RUC meeting.

15731 ***Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)***
The top performing specialty for 15731, plastic surgery, explained that they do not consider this service as part of the same family of codes. The myocutaneous family is intended to describe the large, more difficult flaps that are used for bigger defects and would typically be performed only in a hospital or ASC. Code 15731 was previously developed out of the concerns with site of service that has historically been seen with 15732. They noted that the creation of 15731 was because the described procedure, a paramedian forehead flap used in nasal reconstruction, is quite dissimilar to the types of muscle, myocutaneous, and fasciocutaneous flaps that are coded within the original family. In fact, it is much closer in technique, usage, site of service, and work as the many other codes within the CPT system that describe specific flap reconstruction of the eyelid (e.g. 67973 [eyelid reconstruction with a tarso-conjunctival flap from other eyelid] or mouth (e.g. 40761 [Abbe cross-lip flap]).

Thus, despite the historical origin and placement within the CPT code set, the specialty society asserted that 15731 is notably different than the 15732, 15734, 15736, and 15738 codes. It is the opinion of American Society of Plastic Surgeons (ASPS) that new code 15733 should remain as part of the family with 15734, 15736, and 15738. Code 15730 might best belong with the other codes focused on peri-orbital reconstruction.

15730 ***Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)***
The RUC reviewed the survey results from 58 ophthalmologists and agreed on the following physician time components: 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, intra-service time of 90 minutes, immediate post-time of 17.5 minutes, one half discharge day management (0.5 x 99238), 3 x 99212 post-op office visits and 1x 99213 post-op office visit. The 99213 office visit is associated with removal of the sutures and the drains.

The RUC reviewed the survey 25th percentile work RVU of 14.50 and agreed with the specialty that the survey respondents somewhat overvalued the physician work involved in performing this service. To find an appropriate work RVU crosswalk for CPT code 15730, the RUC reviewed CPT code 36832 *Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)* (work RVU of 13.50, intra-service time of 90 minutes, total time of 276 minutes) and agreed that since both services have 90 minutes intra-service times, both are outpatient procedures, and both have similar post-discharge work, that both services should be valued the same. Therefore, the RUC recommends a direct work RVU crosswalk from code 36832 to code 15730. To further support a work RVU of 13.50, the RUC referenced code 53440 *Sling operation for correction of male urinary incontinence (eg, fascia or*

synthetic) (work RVU = 13.36, intra-time = 90 minutes, total time = 248 minutes) and code 22867 *Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level* (work RVU = 13.50, intra-time = 90 minutes, total time = 271 minutes). **The RUC recommends a work RVU of 13.50 for CPT code 15730.**

15733 ***Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)***
The RUC reviewed the survey results from 34 plastic surgeons and agreed on the following physician time components: pre-service evaluation time of 40 minutes, pre-service positioning of 3 minutes, pre-service scrub/dress/wait time of 15 minutes, intra-service time of 120 minutes, immediate post time of 30 minutes, one-half discharge day management (0.5 x 99238), 2 x 99212 visits and 1 x 99213 visit. The physician work performed in the three postoperative office visits include removal of sutures, evaluation of periodic imaging, pathology, and laboratory reports, as needed; and antibiotic and pain medication adjustments.

The RUC reviewed the survey median work RVU of 15.68 work RVUs and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 15.68, the RUC compared the survey code to 2nd key reference and MPC code 60500 *Parathyroidectomy or exploration of parathyroid(s);* (work RVU 15.60, intra-service time 120 minutes, total time 313 minutes) and noted that both services have identical intra-service times and similar total times. The RUC agreed with the specialty that the survey code involves moderately more intense physician work. To further support a work RVU of 15.68, the RUC referenced code 58544 *Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)* (work RVU = 15.60, intra-time = 120 minutes, total time = 271 minutes) and code 29827 *Arthroscopy, shoulder, surgical; with rotator cuff repair* (work RVU = 15.59, intra-time = 120 minutes, total time = 334 minutes). **The RUC recommends a work RVU of 15.68 for CPT code 15733.**

Affirmation of RUC Recommendations
The RUC affirmed the recent RUC recommendations for CPT codes 15734, 15736, 15738 previously submitted to CMS after review in this coding cycle. The relativity within the family remains correct.

Practice Expense
The PE Subcommittee reviewed the direct practice expense inputs for these services and adjusted the inputs to reflect that CPT code 15733 is only performed in the facility setting. The Subcommittee also noted that the equipment item *exam light* (EQ168), is only needed for the 99213 post-operative visits, which is reflected in the equipment time. The RUC reviewed and approved the direct practice expense inputs as approved by the PE Subcommittee.

Work Neutrality
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Bone Marrow Aspiration (Tab 6)
Alexander Mason, MD (CNS); John Ratliff, MD (AANS); Clemens Schirmer, MD (AANS); William Creevy, MD; John Heiner, MD (AAOS); Karin Swartz, MD (NASS); Charles Mick, MD (NASS); Morgan Lorio, MD (ISASS)

At the September 2016 CPT Editorial Panel meeting a new Category I add-on code (20939) was approved for aspiration of bone marrow for spine autograft procedures as reflected in the literature submitted to CPT. Previously, CPT code 38220 *Bone marrow aspiration* was used to report this. CPT code 38220 was redefined to reflect only bone marrow aspiration for diagnostic purposes. CPT code 38220 had been incorrectly reported because the old code descriptor did not state "diagnostic" aspiration. The CPT Editorial Panel revised the descriptor to more clearly indicate the intent of CPT code 38220. The newly developed CPT code 20939 was valued at the January RUC meeting. This code will only be utilized for spine surgery procedures conducted by orthopedic surgeons and neurosurgeons doing spine autograft procedures.

20939 ***Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 80 physicians and agreed with the following physician time component: intra-service time of 15 minutes.The RUC reviewed the 25th percentile work RVU of 1.16 and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 1.16, the RUC referenced CPT code 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)* (work RVU=1.16, intra-service time of 15 minutes, total time of 15 minutes) and noted that both services have identical intra-services times, total times and intensities, and therefore should be valued similarly. The RUC also reviewed CPT code 64636 *Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)* (work RVU=1.16, intra-service time of 15 minutes, total time of 15 minutes) and noted that both services have identical intra-service times, total times, and intensity, further supporting a work RVU of 1.16 for the survey code. **The RUC recommends a work RVU of 1.16 for CPT code 20939.**

Affirmation of RUC Recommendations
The RUC affirmed the recent RUC recommendations for CPT codes 38220, 38221 and 38222 previously submitted after review in this coding cycle. The relativity within the family remains correct.

Practice Expense
There are no direct expense inputs for CPT code 20939. This service is facility-only and does not require any clinical staff pre-service time.

Nasal-Sinus Endoscopy (Tab 7)
Peter Manes, MD (AAO-HNS); Pete Batra, MD (AAO-HNS); Jay Shah, MD (AAO-HNS)

In April 2015, the Joint CPT/RUC Workgroup accepted the recommendation of the specialty societies with regards to bundling the codes in this group: 31276/31255, 31287/31255, 31288/31255, 31297/31296. In the Final Rule for 2016, a stakeholder indicated that due to changes in technology and technique, several codes that describe endoscopic sinus surgeries can now be furnished in the non-facility setting. According to Medicare claims data, there are a relatively small number of these services furnished in non-facility settings. The RUC noted that this code family is already being reviewed by CPT and RUC for bundling of services. In October

2016 the CPT Editorial Panel created five new codes (31241-31298) with new instructions how to report bundled nasal endoscopy services and revised the parentheticals for codes 31238 and 31254, 31255, 31276, 31287, 31288, 31296 and 31297.

Codes 31231-31297 were included on the level of interest for survey due to the changes in the introductory language, parentheticals or the code descriptor itself. The specialty societies indicated:

1) CPT codes 31231, 31233 and 31235 are not part of the family because these are diagnostic services as contrasted with the endoscopic sinus surgery and balloon sinus dilation codes which are therapeutic services. **The RUC agreed that codes 31231-31235 are not part of this family of services.**
2) CPT codes 31231, 31237, 31238, 31239 and 31240 should not be included as part of the family because they were recently surveyed. 31237-31240 were reviewed (31239 along with Ophthalmology) in April 2013 and 31231 was reviewed in January 2012. **The specialty societies requested and the RUC agreed to affirm the January 2012 and April 2013 work and practice expense recommendations for codes 31231, 31237-31240;**
3) Last, CPT 31290-31294 should not be included as part of family because they are clinically dissimilar. This group of codes are used to treat different disease processes (i.e. CSF leaks and orbital/ocular conditions) rather than disease of the sinus(es). **The RUC agreed that codes 31290-31294 are not part of this family of services.**

The specialty societies proceeded with a survey of 31254-31288, 31241-31298 and 31295-31297 as this is the properly defined family of codes for review and also captures the list of services that the CMS and RUC screens requested for review.

Based on the extensive preliminary review and pre-facilitation with RUC members, the RUC agreed with the specialty societies that the survey results for the majority of the existing codes were disparate due to the lack of similar services with a 000-day global period with a wide range of work RVUs available to be placed on the reference service list (as most were being surveyed or affirmed as part of this family of services) resulting in a low percentage of respondents choosing the same key reference service. Therefore, the RUC suggested either maintaining existing work RVUs or recommending an appropriate direct crosswalk to support the recommendations relative to similar services in the payment schedule.

Balloon Sinuplasty Codes

Medical therapy is typically used to manage chronic and acute rhinosinusitis. However, there are some patients who do not respond to medical therapy and will need surgery, either balloon or functional endoscopic sinus surgery to establish ventilation and drainage. Endoscopic sinus surgery optimizes further medical therapy and allows obtaining cultures and tissues for pathology. Several key things introduced since the 1990s are dramatic advances in medical therapy. Therefore, the typical patient has changed which results in increased intensity of the service for those individuals who must undergo these procedures. Additionally, when these codes were valued as new technology in 2010, they were solely performed in the hospital outpatient setting under general anesthesia. Over time, physicians have increased their skill and comfort level with performing these in the office setting, and now virtually all balloon procedures are done in the office under local/topical anesthesia. This dramatically reduced the pre-time (based on survey time and the package differentials) allotted for these procedures. However, the work has remained unchanged, resulting in increased intensities for these procedures.

The sphenoid balloon sinus is the least intense of these services. It is a straightforward shot enlarging of ostium of the sphenoid sinus. The next intense is the maxillary balloon sinus surgery,

where the physician must work on an angle to creates an opening and enlarge the opening of maxillary sinus. The most intense is the frontal sinus codes, which involves enlarging the ostium of the frontal sinus using angled scopes working adjacent to skull base and orbit to remove tissue and bone establish ventilation between the skull base and the sinus. Additionally, for frontal sinus surgery the physician is normally working at a 45-70 degree angle with both the endoscope and instruments. The frontal ostium is a very narrow space compared to the other sinuses and any scaring leads the patients to additional surgeries to repair.

31295 ***Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or canine fossa***

The RUC reviewed the survey results of 123 otolaryngologists for CPT 31295 and recommends maintaining a work RVU of 2.70. The RUC recommends 15 minutes of evaluation time, 1 minute positioning, 5 minutes of scrub/dress/wait time, 20 minutes of intra-service time and 15 minutes immediate post-service time. The RUC noted that the intra-service time for this service is the same and the difference in total time is primarily due to applying the standard pre-time package. The specialty society noted that the site of service for this procedure has changed and this service is now typically performed in the office setting under topical and local anesthesia. The specialty noted and the RUC agreed that this service is slightly more intense performed on wide awake patient without any sedation. The physician is instrumenting the maxillary sinus and performing multiple dilations at a time while the patient hears and feels the bone cracking and reverberating, which is more intense than previously when the patient was sedated and unaware.

The RUC compared the surveyed code to MPC codes 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70 and 20 minutes intra-service time) and 52281 *Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female* (work RVU = 2.75 and 20 minutes intra-service time) and determined that these similar widely performed services support the existing value and physician time required to perform this service. **The RUC recommends a work RVU of 2.70 for CPT code 31295.**

31297 ***Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)***

The RUC reviewed CPT 31297 and recommends a work RVU of 2.44. The RUC recommends 15 minutes of evaluation time, 1 minute positioning, 5 minutes of scrub/dress/wait time, 20 minutes of intra-service time and 15 minutes immediate post-service time. The RUC noted that the survey top reference services were not comparable for physician work and time. The specialty society recommended and vetted by the robust pre-facilitation of this tab, the RUC agreed that a direct crosswalk to CPT 43215 *Esophagoscopy, flexible, transoral; with removal of foreign body(s)* (work RVU = 2.44 and 20 minutes intra-service time) appropriately accounts for the work and time required to perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the decease in intra-service work as indicated by the survey respondents. The RUC agreed with the specialty society that this service is appropriately less intense and requires less physician work than the frontal sinus code 31296. The specialty society noted that the site of service for this procedure has changed and this service is now typically performed in the office setting under topical and local anesthesia. The specialty noted and the RUC agreed that this service is more intense performed on wide awake patient without any sedation. For additional support, the RUC referenced MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70 and 20 minutes intra-service time). **The RUC recommends a work RVU of 2.44 for CPT code 31297.**

31296 ***Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)***

The RUC reviewed CPT 31296 and recommends a work RVU of 3.10. The RUC recommends 15 minutes of evaluation time, 1 minute positioning, 5 minutes of scrub/dress/wait time, 25 minutes of intra-service time and 15 minutes immediate post-service time. The RUC noted that the survey top reference services were not comparable for physician work and time. The specialty society recommended and the RUC agreed that a direct crosswalk to CPT 19083 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance* (work RVU = 3.10 and 25 minutes intra-service time) appropriately accounts for the work and time required to perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the 5 minute decease in intra-service work as indicated by the survey respondents. The specialty society noted that the site of service for this procedure has changed and this service is now typically performed in the office setting under topical and local anesthesia. The specialty noted and the RUC agreed that this service is more intense performed on wide awake patient without any sedation. The RUC also noted that the frontal sinus is the most complex sinus for the balloon dilation endoscopy services and therefore appropriately valued higher than 31295 and 31297. For additional support, the RUC referenced similar service 45378 *Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (work RVU = 3.26 and 25 minutes intra-service time). **The RUC recommends a work RVU of 3.10 for CPT code 31296.**

31298 ***Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)***

The RUC reviewed the survey results from 114 otolaryngologists and recommends the survey 25th percentile work RVU of 4.50. The RUC recommends 15 minutes of evaluation time, 1 minute positioning, 5 minutes of scrub/dress/wait time, 40 minutes of intra-service time and 15 minutes immediate post-service time. The RUC noted that this is a bundle of 31296 and 31297. The RUC determined that the intensity and complexity, physician work and time for this bundled service is appropriate. The RUC compared the surveyed code to similar services 47532 *Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (eg, percutaneous transhepatic cholangiogram)* (work RVU = 4.25 and 45 minutes intra-service time) and 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C* (work RVU = 4.17 and 30 minutes intra-service time). **The RUC recommends a work RVU of 4.50 for CPT code 31298.**

Functional Endoscopic Sinus Surgery (FESS) Codes

Medical therapy is typically used to manage chronic and acute rhinosinusitis. However, there are some patients who do not respond to medical therapy and will need surgery, either balloon or functional endoscopic sinus surgery to establish ventilation and drainage. Endoscopic sinus surgery optimizes further medical therapy and allows obtaining cultures and tissues for pathology. The typical patient and the intensity of the surgery have changed since these codes were last valued in the 1990s. The specialty society explained the increased intensity for these procedures.

First, the specialty societies indicated that the etiology and pathophysiology of chronic sinusitis has improved significantly since that time, as has the medical treatments clinicians have available. Such improvement in knowledge and treatment has led to greater success with initial medical treatment. In addition, those patients who fail medical therapy may undergo less invasive surgery with balloons, a procedure not available in the early 1990s. As such, the most recalcitrant, complex, difficult patients fail medical therapy and undergo endoscopic sinus surgery. These

patients have greater degree of inflammation and infection, which makes the surgery more technically demanding, as visualization is hampered by the increased vascularity of infected and inflamed tissue.

Second, the outcome of surgery has changed significantly, also greatly increasing the technical demands of the surgery. It is now evident that stripping of mucosa, removal of turbinates, and minor abrasions to structures such as the nasal septum can contribute to scarring and can lead to significantly worse outcomes. Preserving mucosa and avoiding trauma to adjacent structures increases the technical demands and intensity of the surgery. This is of paramount importance in the frontal recess, where a small amount of scarring can lead to complete obstruction of the frontal sinus and the need for revision surgery. This information was not evident back in the early 1990s and, as such, the technical proficiency required to perform the surgery is much greater.

Lastly, the surgery itself has changed significantly since the early 1990s. In the past, the dictum was to avoid critical structures such as the ethmoid skull base and lamina papyracea along the orbit. Dissection stopped before ever reaching these areas. It is now known and taught to future physicians, that in order to obtain optimal outcomes, a comprehensive dissection must be performed. This involves removing partitions along the medial orbital wall, along the ethmoid skull base, and widely opening the sphenoid sinus in the vicinity of the carotid artery and optic nerve. This change represents the most technically challenging and intense portions of endoscopic sinus surgery. This and the other reasons above represent the increase in intensity from the original valuation in the 1990s when compared to present day.

31256 ***Nasal/sinus endoscopy, surgical, with maxillary antrostomy;***
The RUC reviewed CPT 31256 and recommends a work RVU of 3.11, below the survey 25th percentile. The RUC recommends 15 minutes of evaluation time, 8 minutes positioning, 10 minutes of scrub/dress/wait time, 30 minutes of intra-service time and 20 minutes immediate post-service time. The specialty society indicated and the RUC agreed that additional 5 minutes of positioning time is required for the multiple applications of topical decongestant. As is indicated in the description of work, pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. This reflects the typical flow of the operation involves the surgeon performing this prior to scrubbing and gowning. This additional time provided by the survey respondents was provided consistently across the family and is consistent with the increased time provided in positioning. The RUC agreed that this was the typical flow of the procedure to provide the appropriate positioning and preparation of the patient.

The RUC noted that the survey top reference services were not comparable for physician work and time. The specialty society recommended and the RUC agreed that a direct crosswalk to CPT 43247 *Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)* (work RVU = 3.11 and 30 minutes intra-service time) appropriately accounts for the work and time required to perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the decease in intra-service work as indicated by the survey respondents. The RUC noted that the services' intensity was probably undervalued previously based on the understanding of the complexity of this service. For additional support, the RUC referenced similar service 43214 *Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)* (work RVU = 3.40 and 30 minutes intra-service time). **The RUC recommends a work RVU of 3.11 for CPT code 31256.**

31267 ***Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus***
The RUC reviewed CPT 31267 and recommends a work RVU of 4.68. The RUC recommends 15 minutes of evaluation time, 8 minutes positioning, 10 minutes of scrub/dress/wait time, 40 minutes of intra-service time and 20 minutes immediate post-service time. The specialty society indicated and the RUC agreed that additional 5 minutes of positioning time is required for the multiple applications of topical decongestant. As is indicated in the description of work, pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. This reflects the typical flow of the operation involves the surgeon performing this prior to scrubbing and gowning. This additional time provided by the survey respondents was provided consistently across the family and is consistent with the increased time provided in positioning. The RUC agreed that this was the typical flow of the procedure to provide the appropriate positioning and preparation of the patient.

The RUC noted that the survey top reference services were not comparable for physician work and time. The specialty society recommended and the RUC agreed that a direct crosswalk to CPT 45393 *Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed* (work RVU = 4.68 and 40 minutes intra-service time) appropriately accounts for the work and time required to perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the decease in intra-service work as indicated by the survey respondents. The RUC pre-facilitated and fully examined the direct crosswalk and confirmed the physician time, intensity and complexity and physician work are appropriate. For additional support, the RUC referenced similar service 43253 *Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)* (work RVU = 4.73 and 40 minutes intra-service time). **The RUC recommends a work RVU of 4.68 for CPT code 31267.**

31287 ***Nasal/sinus endoscopy, surgical, with sphenoidotomy;***
The RUC reviewed CPT 31287 and recommends a work RVU of 3.50. The RUC recommends 15 minutes of evaluation time, 8 minutes positioning, 13 minutes of scrub/dress/wait time, 30 minutes of intra-service time and 20 minutes immediate post-service time. The specialty society indicated and the RUC agreed that additional 5 minutes of positioning time is required for the multiple applications of topical decongestant. As is indicated in the description of work, pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. This reflects the typical flow of the operation involves the surgeon performing this prior to scrubbing and gowning. This additional time provided by the survey respondents was provided consistently across the family and is consistent with the increased time provided in positioning. The RUC agreed that this was the typical flow of the procedure to provide the appropriate positioning and preparation of the patient.

The RUC noted that the survey top reference services were not comparable for physician work and time. The specialty society recommended and the RUC agreed that a direct crosswalk to CPT 36473 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated* (work RVU = 3.50 and 30 minutes intra-service time) appropriately accounts for the work and time required to

perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the decease in intra-service work as indicated by the survey respondents. The RUC pre-facilitated and fully examined the direct crosswalk and confirmed the physician time, intensity and complexity and physician work are appropriate. For additional support, the RUC referenced similar service 43233 *Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)* (work RVU = 4.07 and 30 minutes intra-service time). **The RUC recommends a work RVU of 3.50 for CPT code 31287.**

31288 ***Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus***
The RUC reviewed CPT 31288 and recommends a work RVU of 4.10. The RUC recommends 15 minutes of evaluation time, 8 minutes positioning, 13 minutes of scrub/dress/wait time, 40 minutes of intra-service time and 20 minutes immediate post-service time. The specialty society indicated and the RUC agreed that additional 5 minutes of positioning time is required for the multiple applications of topical decongestant. As is indicated in the description of work, pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. This reflects the typical flow of the operation involves the surgeon performing this prior to scrubbing and gowning. This additional time provided by the survey respondents was provided consistently across the family and is consistent with the increased time provided in positioning. The RUC agreed that this was the typical flow of the procedure to provide the appropriate positioning and preparation of the patient.

The RUC noted that the survey top reference services were not comparable for physician work and time. The specialty society recommended and the RUC agreed that a direct crosswalk to CPT 44406 *Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures* (work RVU = 4.10 and 40 minutes intra-service time) appropriately accounts for the work and time required to perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the decease in intra-service work as indicated by the survey respondents. The RUC pre-facilitated and fully examined the direct crosswalk and confirmed the physician time, intensity and complexity and physician work are appropriate. For additional support, the RUC referenced similar service 43253 *Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)* (work RVU = 4.73 and 40 minutes intra-service time). **The RUC recommends a work RVU of 4.10 for CPT code 31288.**

31254 ***Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)***
The RUC reviewed CPT 31254 and recommends a work RVU of 4.27. The RUC recommends 15 minutes of evaluation time, 8 minutes positioning, 10 minutes of scrub/dress/wait time, 30 minutes of intra-service time and 20 minutes immediate post-service time. The specialty society indicated and the RUC agreed that additional 5 minutes of positioning time is required for the multiple applications of topical decongestant. As is indicated in the description of work, pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. This reflects the typical flow of the operation involves the surgeon performing this prior to scrubbing and

gowning. This additional time provided by the survey respondents was provided consistently across the family and is consistent with the increased time provided in positioning. The RUC agreed that this was the typical flow of the procedure to provide the appropriate positioning and preparation of the patient.

The RUC agreed that the intensity for this service is higher than the functional endoscopic sinus surgery on the maxillary or sphenoid sinuses. The physician is working closer to the orbit and skull base and the risk of major complications such as injury to eye muscles, bleeding into the eye or brain fluid leak become more inherent to these specific technical procedures.

The RUC noted that the survey top reference services were not comparable for physician work and time. The specialty society recommended and the RUC agreed that a direct crosswalk to CPT 43243 *Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices* (work RVU = 4.27 and 30 minutes intra-service time) appropriately accounts for the work and time required to perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the decrease in intra-service work as indicated by the survey respondents. The RUC pre-facilitated and fully examined the direct crosswalk and confirmed the physician time, intensity and complexity and physician work are appropriate. For additional support, the RUC referenced similar service 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.46 and 30 minutes intra-service time). **The RUC recommends a work RVU of 4.27 for CPT code 31254.**

31255 ***Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)***
The RUC reviewed CPT 31255 and recommends a work RVU of 5.75. The RUC recommends 15 minutes of evaluation time, 8 minutes positioning, 10 minutes of scrub/dress/wait time, 45 minutes of intra-service time and 20 minutes immediate post-service time. The specialty society indicated and the RUC agreed that additional 5 minutes of positioning time is required for the multiple applications of topical decongestant. As is indicated in the description of work, pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. This reflects the typical flow of the operation involves the surgeon performing this prior to scrubbing and gowning. This additional time provided by the survey respondents was provided consistently across the family and is consistent with the increased time provided in positioning. The RUC agreed that this was the typical flow of the procedure to provide the appropriate positioning and preparation of the patient.

The RUC noted that the survey top reference services were not comparable for physician work and time. The RUC indicated that the intensity may be slightly higher than the anterior only code 31254, but there were no other comparable crosswalks. The specialty society recommended and the RUC agreed that a direct crosswalk to MPC code 52351 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic* (work RVU = 5.75 and 45 minutes intra-service time) appropriately accounts for the work and time required to perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the decease in intra-service work as indicated by the survey respondents. The RUC pre-facilitated and fully examined the direct crosswalk and confirmed the physician time, intensity and complexity and physician work are appropriate. For additional support, the RUC referenced similar service 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU = 6.75 and 45 minutes intra-service time). **The RUC recommends a work RVU of 5.75 for CPT code 31255.**

31276 ***Nasal/sinus endoscopy, surgical; with frontal sinus exploration, including removal of tissue from frontal sinus, when performed***
The RUC reviewed CPT 31276 and recommends a work RVU of 6.75. The RUC recommends 15 minutes of evaluation time, 8 minutes positioning, 10 minutes of scrub/dress/wait time, 45 minutes of intra-service time and 20 minutes immediate post-service time. The specialty society indicated and the RUC agreed that additional 5 minutes of positioning time is required for the multiple applications of topical decongestant. As is indicated in the description of work, pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. This reflects the typical flow of the operation involves the surgeon performing this prior to scrubbing and gowning. This additional time provided by the survey respondents was provided consistently across the family and is consistent with the increased time provided in positioning. The RUC agreed that this was the typical flow of the procedure to provide the appropriate positioning and preparation of the patient.

The RUC noted that this is the most intense and complex functional endoscopic sinus surgeries. The specialty societies reiterated that this is the most difficult working with 45-70 degree endoscope working in the narrow confines up in the frontal recess. The frontal sinus is the least forgiving, if the physician inadvertently strips the mucosa or develop scarring the risk of failure is significant. The RUC noted that the survey top reference services were not comparable for physician work and time. The specialty society recommended and the RUC agreed that a direct crosswalk to CPT code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU = 6.75 and 45 minutes intra-service time) appropriately accounts for the work and time required to perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the decease in intra-service work as indicated by the survey respondents. The RUC pre-facilitated and fully examined the direct crosswalk and confirmed the physician time, intensity and complexity and physician work are appropriate. For additional support, the RUC referenced similar service 37192 *Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 7.10 and 45 minutes intra-service time). **The RUC recommends a work RVU of 6.75 for CPT code 31276.**

New Bundled Codes

31253 ***Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed***
The RUC reviewed the survey results from 128 otolaryngologists and determined the survey 25th percentile work RVU of 9.00 appropriately accounts for the physician work required to perform this service. The RUC recommends 15 minutes of evaluation time, 8 minutes positioning, 13 minutes of scrub/dress/wait time, 70 minutes of intra-service time and 20 minutes immediate post-service time. The specialty society indicated and the RUC agreed that additional 5 minutes of positioning time is required for the multiple applications of topical decongestant. As is indicated in the description of work, pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. This reflects the typical flow of the operation involves the surgeon performing this prior to scrubbing and gowning. This additional time provided by the survey respondents was provided consistently across the family and is consistent with the increased time provided in

positioning. The RUC agreed that this was the typical flow of the procedure to provide the appropriate positioning and preparation of the patient.

The RUC noted that this new service bundles 31255 (recommended work RVU = 5.75 and 45 minutes intra-time) and 31276 (recommended work RVU = 6.75 and 45 minutes intra-service time). The RUC notes that the survey physician time and 25th percentile work RVU appropriately accounts for the efficiencies of these services being performed together. The RUC compared the surveyed code to key reference 93582 *Percutaneous transcatheter closure of patent ductus arteriosus* (work RVU = 12.31 and 60 minutes intra-service time) and noted that the surveyed code is more intense and complex. For additional support the RUC referenced CPT code 47539 *Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, without placement of separate biliary drainage catheter* (work RVU = 8.75 and 75 minutes intra-service time). **The RUC recommends a work RVU of 9.00 for CPT code 31253.**

31257 ***Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy***
The RUC reviewed CPT 31257 and recommends a work RVU of 8.00. The RUC recommends 15 minutes of evaluation time, 8 minutes positioning, 15 minutes of scrub/dress/wait time, 60 minutes of intra-service time and 20 minutes immediate post-service time. The specialty society indicated and the RUC agreed that additional 5 minutes of positioning time is required for the multiple applications of topical decongestant. As is indicated in the description of work, pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. This reflects the typical flow of the operation involves the surgeon performing this prior to scrubbing and gowning. This additional time provided by the survey respondents was provided consistently across the family and is consistent with the increased time provided in positioning. The RUC agreed that this was the typical flow of the procedure to provide the appropriate positioning and preparation of the patient.

The RUC recommends a direct crosswalk to CPT code 52356 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU = 8.00 and 60 minutes intra-service time). The RUC noted that this new service bundles 31255 (recommended work RVU = 5.75 and 45 minutes intra-time) and 31287 (recommended work RVU = 3.50 and 30 minutes intra-service time). The RUC notes that the recommended physician time and work RVU appropriately accounts for the efficiencies of these services being performed together. The RUC confirmed the physician time and work for 31257 and 31241 are the same and thus should be valued the same. The additional support the RUC referenced CPT code 47539 *Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, without placement of separate biliary drainage catheter* (work RVU = 8.75 and 75 minutes intra-service time). **The RUC recommends a work RVU of 8.00 for CPT code 31257.**

31259 ***Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus***
The RUC reviewed CPT 31259 and recommends a work RVU of 8.48. The RUC recommends 15 minutes of evaluation time, 8 minutes positioning, 15 minutes of scrub/dress/wait time, 65

minutes of intra-service time and 20 minutes immediate post-service time. The specialty society indicated and the RUC agreed that additional 5 minutes of positioning time is required for the multiple applications of topical decongestant. As is indicated in the description of work, pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. This reflects the typical flow of the operation involves the surgeon performing this prior to scrubbing and gowning. This additional time provided by the survey respondents was provided consistently across the family and is consistent with the increased time provided in positioning. The RUC agreed that this was the typical flow of the procedure to provide the appropriate positioning and preparation of the patient.

The RUC recommends a direct crosswalk to CPT code 43274 *Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent* (work RVU = 8.48 and 68 minutes intra-service time). The RUC noted that this new service bundles 31255 (recommended work RVU = 5.75 and 45 minutes intra-time) and 31288 (recommended work RVU = 4.10 and 40 minutes intra-service time). The RUC notes that the recommended physician time and work RVU appropriately accounts for the efficiencies of these services being performed together. The additional support the RUC referenced CPT code 47539 *Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, without placement of separate biliary drainage catheter* (work RVU = 8.75 and 75 minutes intra-service time). **The RUC recommends a work RVU of 8.48 for CPT code 31259.**

New Sphenopalatine Artery Code

31241 ***Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery***
The RUC reviewed CPT 31241 and recommends a work RVU of 8.00. The RUC recommends 15 minutes of evaluation time, 8 minutes positioning, 15 minutes of scrub/dress/wait time, 60 minutes of intra-service time, 25 minutes immediate post-service time and a half day discharge day management 99238. The specialty society indicated and the RUC agreed that additional 5 minutes of positioning time is required for the multiple applications of topical decongestant. As is indicated in the description of work, pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. This reflects the typical flow of the operation involves the surgeon performing this prior to scrubbing and gowning. This additional time provided by the survey respondents was provided consistently across the family and is consistent with the increased time provided in positioning. The RUC agreed that this was the typical flow of the procedure to provide the appropriate positioning and preparation of the patient.

The specialty society noted that they failed to use the 000-day survey instrument that questions the number and type of visits. However, during review of the direct practice expense inputs the specialty society confirmed that a half day discharge day management is necessary as the patients typically stay overnight to be monitored for further bleeding and monitored due to the recent acute blood loss.

The RUC recommends a direct crosswalk to CPT code 52356 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent*

(eg, Gibbons or double-J type) (work RVU = 8.00 and 60 minutes intra-service time). The RUC confirmed the physician time and work for 31257 and 31241 are the same and thus should be valued the same. For additional support the RUC referenced CPT code 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 8.58 and 60 minutes intra-service time). **The RUC recommends a work RVU of 8.00 for CPT code 31241.**

Affirmation of RUC Recommendations
The RUC affirmed the recent RUC recommendations for CPT codes 31231, 31237, 31238, 31239 and 31240, previously submitted after review in this coding cycle. The relativity within the family remains correct.

Work Neutrality
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs as recommended by the specialty and reduced the pre-service time for all the services to be similar to pre-service time for 000 day global endoscopic procedures. The PE Subcommittee reduced the overall time for CPT code 31241 because of its emergent nature and also to account for any service that is typically reported with an Evaluation and Management service. In addition, the PE Subcommittee added a half discharge day management for 31241. This is unusual for a 000 day global, however the Subcommittee determined that it was appropriate because the patient will be staying overnight in the facility setting. The Subcommittee increased the time to correct cleaning of the instrument pack for CPT codes 31254, 31295, 31296, 31297 and 31298 which had incorrectly been assigned 10 minutes to clean a basic pack previously, but requires 15 minutes to clean a medium pack. The Subcommittee also verified that a full balloon is necessary for the 31298 because this service includes two sinuses. The Subcommittee noted that a half catheter for each balloon is necessary for the rest of the services because multiple sinuses, typically two, could be balloon dilated at the same time. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Cryoablation of Pulmonary Tumors (Tab 8)
Michael Hall, MD (SIR); Jerry Niedzwiecki, MD (SIR); Curtis Anderson, MD (SIR); Kurt Schoppe, MD (ACR) and Daniel Wessell, MD (ACR)
Facilitation Committee #2

The CPT Editorial Panel created a new code (32994) to report cryoablation of pulmonary tumors, and revision of 32998 to include imaging for ablation of tumor. Category III code 0340T will be deleted.

32998 ***Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency***
The RUC reviewed the survey results from 38 physicians and agreed with the following physician time components: 33 minutes for pre-service evaluation time, 10 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, intra-service time of 85 minutes, and immediate post-time of 30 minutes.

The RUC reviewed the survey 25th percentile work RVU of 8.00 and survey median work RVU of 9.30. The specialty society indicated that the 25th percentile work RVU was too low to value

this service with imaging guidance. The specialty societies indicated and the RUC agreed to crosswalk CPT code 32998 to a similar service that radiologists and interventional radiologists perform, CPT code 47540 *Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)* (work RVU = 9.03 and intra-service time of 85 minutes). For additional support, the RUC also referenced CPT code 52355 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor* (work RVU = 9.00 and intra-service time of 90 minutes). **The RUC recommends a work RVU of 9.03 for CPT code 32998.**

32994 ***Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation***
The RUC reviewed the survey results from 38 physicians and agreed with the following physician time components: 33 minutes for pre-service evaluation time, 10 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, intra-service time of 90 minutes, and immediate post-time of 30 minutes.

The RUC reviewed the survey 25th percentile work RVU of 8.13 and survey median work RVU of 9.30. The specialty society indicated that the 25th percentile work RVU was too low to value this service with imaging guidance. The specialty societies indicated and the RUC agreed to crosswalk CPT code 32994 to a similar service that radiologists and interventional radiologists perform, CPT code 47540 *Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)* (work RVU = 9.03 and intra-service time of 85 minutes). For additional support, the RUC also referenced CPT code 52355 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor* (work RVU = 9.00 and intra-service time of 90 minutes). **The RUC recommends a work RVU of 9.03 for CPT code 32994.**

Practice Expense
The Practice Expense (PE) Subcommittee discussed the direct practice expense inputs for CPT codes 32998 and 32994 and determined that the extensive use of clinical staff time in the pre-service period is not necessary for this procedure. The Subcommittee reduced the time to 9 minutes in the non-facility setting and 19 minutes in the facility setting consistent with similar services for the standard pre-service inputs. The Subcommittee reviewed the specialties request for an additional 6 minutes to *Review patient clinical extant information and questionnaire* and agreed with the specialty that there is additional time needed but determined that 2 minutes is more appropriate for this activity. The PE Subcommittee discussed the clinical staff needed to assist the physician with this service and agreed with the specialty societies that the standard for an additional circulator used in interventional radiology services applies to these codes. The standard includes one staff to assist the physician and a separate staff represented by two clinical staff types to act as a circulator. For these services it is an CT technologist, L046A, "hip to hip" with the physician to assist during the procedure and a CT technologist, L046A (75%) and a RN/LPN/MTA, L037D (25%) to circulate. The Subcommittee discussed that 3 minutes is required for the cleaning of additional ablation generator and equipment. The clinical labor task of clean scope is being used as a proxy for cleaning this equipment. The specialty societies noted that they believe there is an error in the change of pricing for the supply item *probe,*

radiofrequency, 3 array (StarBurstSDE) (SD109) and will be submitting invoices to CMS to correct the pricing of this supply. A representative of CMS questioned the need for 3 probes, supply item *probe, cryoablation, renal* (SD233). The specialty stated that the number of probes is dependent on the size of the tumor and that for the size tumor that would require this type of procedure 3 probes are typical in order to get sufficient margins around the tumor, this is also supported in the literature. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

New Technology
CPT codes 32994 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Artificial Heart System Procedures (Tab 9)
James M. Levett, MD (STS); Stephen J. Lahey, MD (AATS); Kirk R. Kanter, MD (STS); Vigneshwar Kasirajan, MD (STS)

In September 2016, the CPT Editorial Panel deleted Category III codes 0051T-0053T and created three Category I codes to report artificial heart system procedures.

The specialty societies indicated that these services are rarely performed in the US. Currently, there are 76 centers in the US certified to perform these procedures. Only those hospitals that are certified transplant centers, working on becoming a transplant center, use MCS devices, or JCAHO certified DT LVAD center are certified. Certain exceptions may apply such as some children's centers may only have had experience with the Berlin Heart. There is currently only one total artificial heart (TAH) available in the US market. Other TAH manufactures have either gone out of business or are not currently implanting in the US. The specialty societies used a targeted list approved by the Research Subcommittee from the company that included 128 individuals who are considered implanting surgeons, explanting surgeons or assistants.

33927 ***Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy***
The RUC reviewed the survey data from 24 cardiothoracic surgeons and determined that the survey median work RVU of 49.00 appropriately accounts for the work required to perform this service. The RUC recommends 60 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 20 minutes pre-service scrub/dress/wait time, 360 minutes intra-service time and 105 minutes immediate post-service time. Of the 24 respondents 18 indicated they had experience with this service and 6 with no experience performing this service in the last 12 months. The top key reference service selected for comparison by all respondents was CPT code 33983 *Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass* (work RVU = 44.54 and 345 minutes intra-service time, 560 total time). This code was the highest valued reference code available on the reference service list and the respondents for the combined and experienced groups all indicated that that code being surveyed was significantly more complex in the intensity for all measures examined compared to the key reference code 33983. The specialty societies indicated and the RUC agreed that the median physician time data of 360 minutes from the experienced respondents was more representative of the work involved in the TAH implantation. The specialty societies indicated and the RUC agreed that the respondents with no experience underestimated the work involved. The RUC also agreed that the time involved for implantation of biventricular pumps and the associated components with the replacement of total heart function with right and left sided circulation management was longer then that represented by physician time of CPT code 33983, which involves replacement of only the pump for one ventricle and the management of supplementing partial heart function.

The RUC also compared the surveyed code to the second key reference service 33979 *Insertion of ventricular assist device, implantable intracorporeal, single ventricle* (work RVU = 37.50 and 280 minutes intra-service time, 465 minutes total time) and noted that the survey respondents indicated that the surveyed code was more intense and complex on all measures examined (e.g. mental effort, technical skill, physical effort, psychological stress) and requires more physician work to perform. Therefore, the surveyed code is valued appropriately higher than CPT code 33979. **The RUC recommends a work RVU of 49.00 for CPT code 33927.**

33929 ***Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)***
The RUC recommends that CPT code 33929 be carrier priced until code 33927 for the TAH implantation comes up for new technology review and/or the service is more widely utilized in the US. The specialty societies indicated that the survey respondents may have considered the work of some of the heart transplant in addition to the work for removal of the TAH instead of just the work associated with the removal of the TAH components when valuing the procedure. **The RUC recommends that CPT code 33929 be carrier priced.**

33928 ***Removal and replacement of total replacement heart system (artificial heart)***
The RUC recommends that CPT code 33928 be carrier priced until code 33927 for the TAH implantation comes up for new technology review and/or the service is more widely utilized in the US. This service is rarely provided and only three of the 20 respondents had any experience with the procedure. The CPT Editorial Panel discussed the low utilization of this procedure at the meeting and anticipated possible difficulty to survey. **The RUC recommends that CPT code 33928 be carrier priced.**

Practice Expense
There are no direct practice expense inputs for this facility-only service.

New Technology
CPT codes 33927, 33929 and 33928 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Endovascular Repair Procedures (EVAR) (Tab 10)
Matthew Sideman, MD (SVS); Robert Zwolak, MD (SVS); Charles Mabry, MD (ACS); Nader Massarweh, MD (ACS); Michael Hall, MD; Curtis Anderson, MD (SIR)

In October 2015, the CPT/RUC Joint Workgroup on Codes Reported Together recommended to bundle endovascular abdominal aortic aneurysm repair (EVAR) codes with radiologic supervision and interpretation (34800, 34802, 34803, 34804, 34825, 75952 and 75953). In September 2016, the CPT Editorial Panel bundled endovascular repair of abdominal aortic aneurysm and radiologic supervision and interpretation services with the addition of 16 new codes 34701-34716, revision of 4 category I codes (34812, 34820, 34833 and 34834), deletion of 14 codes (34800-34806, 34825, 34826, 34900, 75952-75954, 93982, 0255T), and revision of category III code 0254T.

Background
During the multispecialty presentation at the January 2017 RUC meeting, the presenters provided a comprehensive history of this family of services and also their rationale in creating this new coding structure. They noted that the first two devices for endovascular repair of abdominal aortic aneurysms received FDA approval in 1999, and a family of EVAR codes was presented to the RUC in April 2000. At that time, EVAR was typically performed by a team of physicians including vascular surgeons and interventional radiologists. Thus, the coding structure was created according

to component coding standards for endovascular procedures. The EVAR family of codes appeared in the 2001 Medicare Physician Fee Schedule and the values have remained stable since that time.

At the January 2014 RUC meeting, the RAW identified CPT codes 34802, 34812, and 34825 in the pre-time screen for procedures having pre-service minutes in excess of standard package times. These long pre-times had been approved by the RUC to reflect the extensive pre-operative endograft sizing work that is required to carry out a successful operation. The need for the surgeon to perform extensive pre-operative measurements of multiple diameters and lengths, and to then perform endograft sizing, is still required physician work today.

There have been several significant paradigm shifts since the codes were originally valued. First, the specialty societies observed that there has been an increased emphasis placed on bundling codes that are commonly performed together by the same provider. Second, providers of this service only rarely work in teams today and the typical service is performed by one clinician who does the surgical and radiologic portions of the repair. Finally, providers have begun performing EVAR for treatment of life-threatening ruptured aortic aneurysms, a practice that was never considered viable in April 2000 when the codes were originally valued.

For all of these reasons, the multispecialty panel decided to propose to the CPT Editorial Panel for this the family of services that describe EVAR to be restructured. The CPT Editorial Panel approved the final coding changes at the September 2016 CPT meeting. The new codes incorporate many of the concerns described above and are outlined as follow:

1. Catheter placement is now bundled into the main procedure.
2. Radiologic supervision & interpretation is now bundled into the main procedure.
3. All distal extensions performed to the common iliac artery bifurcations are now bundled into the main procedure.
4. All proximal extensions performed to the lowest renal artery are now bundled into the main procedure.
5. The coding structure is now based on the anatomy of the disease rather than the device used to treat the aneurysm.
6. New codes have been created for the significantly different work of EVAR for ruptured aneurysms.
7. The global period has been changed from 0-day to ZZZ for the access procedures since these are never performed as stand-alone services.

Pre-service Time (34701-34708, 34710, 34712)

The specialties noted that there is significant pre-service time and work that goes into providing these procedures to review the aneurysm anatomy on CT angiogram, confirm the suitability of the anatomy for EVAR, make a large number of aortic diameter and center-line length measurements, review available endograft sizes and develop an operative plan that will successfully treat the pathology at hand. This time was originally added to the pre-service time of the original codes (leading to identification in the RAW screen). This service is provided after evaluation in the office, but more than 24 hours prior to the procedure. Therefore, prior to conducting their survey's, the multispecialty panel received approval to add an additional question to the RUC survey to capture time spent planning for EVAR. The specialties noted that this is consistent with the code descriptors which include the phrase "including pre-procedure sizing and device selection." They also noted that this is also consistent with CMS' statement regarding to how to handle the the Fenestrated Endovascular Repair (FEVAR) Endograft Planning code 34839 in the CY2015 Final Rule: "CY 2014 final rule and CMS said "In general, we prefer that planning be bundled with the underlying service, and we have no reason to believe bundling is not appropriate in this case. Accordingly, we are assigning a PFS procedure status indicator of B

(Bundled Code) to CPT code 34839.". The RUC agreed that the additional planning time should therefore included in the total evaluation minutes and becomes part of the pre-service work. The specialty noted and the RUC agreed that the emergent codes (34702, 34704, 34706 and 34708) should have less time for EVAR planning relative to the planned codes (34701, 34703, 34705, 34707 and 34710).

The RUC agreed with the specialties that pre-service package 4 was appropriate for EVAR procedures with adjustment to the times for addition of EVAR planning time. The specialties noted and the RUC agreed that the recommended pre-service times appropriately captured the additional work the day before and the day of the procedure to ensure that all necessary supplies are available for the operation, to ensure that the radiologic equipment is operational and prepared for the procedure, and to re-review the extensive anatomic imaging prior to performing the procedure. An additional 17 minutes of positioning time has been added to codes 34701-34708 to account for positioning the imaging equipment and operating room equipment to minimize conflicts between equipment and patient during surgery, appropriately positioning the patient with arms tucked as indicated, and confirming that all EKG leads and IV, Foley and arterial catheter lines are clear from the areas to be imaged during the procedure.

Immediate Post-service Time (34701-34708, 34710, 34712)
Post-service package 9B would apply for these complex procedures, however, this package only includes 5 minutes for "operative note" which is not sufficient time for endovascular procedures that have radiologic supervision & interpretation bundled into the code. There is significantly more time involved to review all images and cines, annotate appropriate images, dictate radiologic findings, and document radiation exposure and contrast volumes. The RUC agreed with the specialties that the survey median times should be utilized for the immediate post-service time in order to capture the additional work above and beyond the standard post-time package.

Post-operative Visits (34701-34708, 34710, 34712)
The specialty societies noted that the post-operative in-hospital visits include: interval history-taking for new complaints of pain or neurovascular compromise; close monitoring of abdominal tenderness, lower extremities for tenderness or emboli, all arterial access sites for bleeding or hematoma formation, blood pressure, urinary output for signs of hypovolemia, pulse and perfusion, neurologic evaluation for any signs of spinal cord ischemia and Hemoglobin and coagulation labs. The need for routine or advanced imaging is assessed daily. Post-op CT scans are obtained, either during the inpatient stay or early in the post-discharge time period. Progress notes are recorded daily. Patient and family questions are answered. Orders are updated daily. Rounds with nursing staff and other consultants are performed daily. Discharge day management includes communicating with all support services such as visiting nurses, referring physicians, review interval chart notes, answer patient and family questions, evaluate all pre-discharge labs, evaluate and redress the incisions, assess pain score, and perform medication reconciliation. Surgeon discusses home restrictions (ie, diet, activity, bathing) with patient and family members; writes orders for home care, discharge medications and supplies; and completes all appropriate medical records, including day of discharge progress notes and final discharge instructions. At each office visit, the surgeon solicits an interval history for ongoing or new symptoms, examines the abdomen for tenderness, examines arterial access sites and surgical incisions for inflammation, drainage, wound infection; examines lower extremities for adequate perfusion. The surgeon orders diagnostic blood tests and/or imaging studies based on findings and reviews post-op CT scans and ultrasounds for possible endoleak. They also make clinical decisions regarding need for repeat surgical intervention and provide wound care when necessary. They also remove staples and sutures as indicated, answer patient/family questions and write prescriptions for medication and therapy, as necessary. In addition, they discuss progress with referring physician (verbal and written) and record progress notes for the medical chart.

34701 ***Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)***
The RUC reviewed the survey results from 55 physicians and agreed on the following physician time components: 60 minutes for EVAR planning time, 50 minutes for pre-service evaluation time, 20 minutes for pre-service positioning time, 20 minutes for pre-service scrub/dress/wait, 120 minutes for intra-service time, 40 minutes for immediate post-time, 1 99233 visit, 1 99232 visit, 1 99238 discharge visit, 1 99213 office visit and 1 99212 office visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 25.00. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 33254 *Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)* (work RVU of 23.71, intra-service time of 120 minutes, total time of 416 minutes) and noted that both services have identical intra-service times, the same number of post-operative visits and a similar amount of total physician work. Therefore, the RUC recommends a direct work RVU crosswalk from 33254 to 34701. **The RUC recommends a work RVU of 23.71 for CPT code 34701.**

34702 ***Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)***
The RUC reviewed the survey results from 49 physicians and agreed on the following physician time components: 30 minutes for EVAR planning time, 30 minutes for pre-service evaluation time, 20 minutes for pre-service positioning time, 20 minutes for pre-service scrub/dress/wait, 120 minutes for intra-service time, 60 minutes for immediate post-time, 1 99291 visit, 2 99233 visits, 2 99232 visits, 1 99231 visit, 1 99238 discharge visit, 1 99214 office visit, 1 99213 office visit and 1 99212 office visit. The RUC agreed with the specialties that the emergent codes require many more post-operative visits relative to the planned EVAR procedures.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the median work RVU of 36.00. To justify a work RVU of 36.00, the RUC compared the survey code to CPT code 33390 *Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (ie, valvotomy, debridement, debulking, and/or simple commissural resuspension)* (work RVU of 35.00, intra-service time of 180 minutes, total time of 622 minutes) and noted that although the reference code has more intra-service time, the survey code has much more total time and involves a similar amount of physician work. **The RUC recommends a work RVU of 36.00 for CPT code 34702.**

34703 ***Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uniiliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)***
The RUC reviewed the survey results from 54 physicians and agreed on the following physician time components: 60 minutes for EVAR planning time, 50 minutes for pre-service evaluation time, 20 minutes for pre-service positioning time, 20 minutes for pre-service scrub/dress/wait, 150 minutes for intra-service time, 35 minutes for immediate post-time, 1 99233 visit, 1 99232 visit, 1 99238 discharge visit, 1 99213 office visit and 1 99212 office visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 30.25. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 34151 *Embolectomy or thrombectomy, with or without catheter; renal, celiac, mesentery, aortoiliac artery, by abdominal incision* (work RVU of 26.52, intra-service time of 150 minutes, total time of 508 minutes) and noted that both services have identical intra-service times, a similar amount of total time and involve a similar amount of total physician work. Therefore, the RUC recommends a direct work RVU crosswalk from 34151 to 34703. **The RUC recommends a work RVU of 26.52 for CPT code 34703.**

34704 ***Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uniiliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)***
The RUC reviewed the survey results from 53 physicians and agreed on the following physician time components: 30 minutes for EVAR planning time, 30 minutes for pre-service evaluation time, 20 minutes for pre-service positioning time, 20 minutes for pre-service scrub/dress/wait, 180 minutes for intra-service time, 60 minutes for immediate post-time, 1 99291 visit, 2 99233 visits, 2 99232 visits, 1 99231 visit, 1 99238 discharge visit, 1 99214 office visit, 1 99213 office visit and 1 99212 office visit. The RUC agreed with the specialties that the emergent codes require many more post-operative visits relative to the planned EVAR procedures.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the median work RVU of 45.00. To justify a work RVU of 45.00, the RUC compared the survey code to CPT code 43415 *Suture of esophageal wound or injury; transthoracic or transabdominal approach* (work RVU of 44.88, intra-service time of 180 minutes, total time of 842) and noted that both services have identical intra-service time and involve a similar total amount of physician work. Although the reference code has more total time, the survey code is a much more intense procedure to perform. **The RUC recommends a work RVU of 45.00 for CPT code 34704.**

34705 ***Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-biiliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)***
The RUC reviewed the survey results from 54 physicians and agreed on the following physician time components: 60 minutes for EVAR planning time, 50 minutes for pre-service evaluation time, 20 minutes for pre-service positioning time, 20 minutes for pre-service scrub/dress/wait, 150 minutes for intra-service time, 40 minutes for immediate post-time, 1 99233 visit, 1 99232 visit, 1 99238 discharge visit, 1 99213 office visit and 1 99212 office visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 32.28. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 33641 *Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch* (work RVU of 29.58, intra-service time of 164 minutes, total time of 562 minutes) and noted that although the reference code has somewhat more intra-service and total time, both services involve a similar amount of total physician work as the survey code is a more intense procedure to perform. Therefore, the RUC recommends a direct work RVU crosswalk from 33641 to 34705. **The RUC recommends a work RVU of 29.58 for CPT code 34705.**

34706 ***Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-biiliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)***
The RUC reviewed the survey results from 54 physicians and agreed on the following physician time components: 30 minutes for EVAR planning time, 30 minutes for pre-service evaluation time, 20 minutes for pre-service positioning time, 20 minutes for pre-service scrub/dress/wait, 178 minutes for intra-service time, 60 minutes for immediate post-time, 1 99291 visit, 2 99233 visits, 2 99232 visits, 1 99231 visit, 1 99238 discharge visit, 1 99214 office visit, 1 99213 office visit and 1 99212 office visit. The RUC agreed with the specialties that the emergent codes require many more post-operative visits relative to the planned EVAR procedures.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the median work RVU of 45.00. To justify a work RVU of 45.00, the RUC compared the survey code to CPT code 43415 *Suture of esophageal wound or injury; transthoracic or transabdominal approach* (work RVU of 44.88, intra-service time of 180 minutes, total time of 842) and noted that the services have very similar intra-service times and involve a similar total amount of physician work. Although the reference code has more total time, the survey code is a much more intense procedure to perform. **The RUC recommends a work RVU of 45.00 for CPT code 34706.**

34707 ***Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)***
The RUC reviewed the survey results from 54 physicians and agreed on the following physician time components: 60 minutes for EVAR planning time, 50 minutes for pre-service evaluation time, 20 minutes for pre-service positioning time, 20 minutes for pre-service scrub/dress/wait, 120 minutes for intra-service time, 40 minutes for immediate post-time, 1 99233 visit, 1 99232 visit, 1 99238 discharge visit, 1 99213 office visit and 1 99212 office visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 24.00. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 37660 *Ligation of common iliac vein* (work RVU of 22.28, intra-service time of 120 minutes, total time of 397 minutes) and noted that both services have identical total time and involve a similar amount of total physician work. Therefore, the RUC recommends a direct work RVU crosswalk from 37660 to 34707. **The RUC recommends a work RVU of 22.28 for CPT code 34707.**

34708 ***Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)***
The RUC reviewed the survey results from 54 physicians and agreed on the following physician time components: 30 minutes for EVAR planning time, 30 minutes for pre-service evaluation time, 20 minutes for pre-service positioning time, 20 minutes for pre-service scrub/dress/wait, 120 minutes for intra-service time, 60 minutes for immediate post-time, 1 99291 visit, 2 99233 visits, 2 99232 visits, 1 99231 visit, 1 99238 discharge visit, 1 99214 office visit, 1 99213 office visit and 1 99212 office visit. The RUC agreed with the specialties that the emergent codes require many more post-operative visits relative to the planned EVAR procedures.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the median work RVU of 36.50. To justify a work RVU of 36.50, the RUC compared the survey code to CPT code 33390 *Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (ie, valvotomy, debridement, debulking, and/or simple commissural resuspension)* (work RVU of 35.00, intra-service time of 180 minutes, total time of 622 minutes) and noted that although the reference code has more intra-service time, the survey code has much more total time and involves slightly more total physician work. **The RUC recommends a work RVU of 36.50 for CPT code 34708.**

34709 ***Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting when performed, per vessel treated (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 33 physicians and agreed on the following physician time components: 60 minutes of intra-service time. The specialty societies explained that the difference for 34709 compared to extension codes in the prior coding method is that the treatment zone is now explicitly defined as from the level of the lowest renal artery to the iliac bifurcation for the devices that extend from the aorta into the iliac. In previous coding, when extensions could be placed within that treatment zone and coded, that work is now bundled into 34701-34708. By definition, to use 34709 the surgeon is placing an extension beyond the treatment zone.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 6.50. To justify a work RVU of 6.50, the RUC compared the survey code to CPT code 37233 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)* (work RVU of 6.50, intra-service time of 60 minutes, total time of 62 minutes) and noted that both services have identical intra-service times and near identical total times. The value for 34709 is higher than the value for 34711 which is a very similar service; however, clinically speaking, the additional endograft extension placed in a delayed fashion for 34711 could be within the previous treatment zone of the initial endograft placement and is therefore less intense then an extension placed at the time of initial endografts deployment. **The RUC recommends a work RVU of 6.50 for CPT code 34709.**

34710 ***Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting when performed; initial vessel treated***
The RUC reviewed the survey results from 33 physicians and agreed on the following physician time components: 60 minutes for EVAR planning time, 50 minutes for pre-service evaluation time, 15 minutes for pre-service positioning time, 15 minutes for pre-service scrub/dress/wait, 90 minutes for intra-service time, 30 minutes for immediate post-time, 1 99232 visit, 1 99231 visit, 1 99238 discharge visit, 1 99213 office visit and 1 99212 office visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 15.00. To justify a work RVU of 15.00, the RUC compared the survey code to MPC code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (work RVU of 15.37, intra-service time of 90 minutes, total time of 362 minutes) and noted that both services have identical intra-service time and the survey code has more total time. **The RUC recommends a work RVU of 15.00 for CPT code 34710.**

34711 ***Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting when performed; each additional vessel treated (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 33 physicians and agreed on the following physician time components: 60 minutes of intra-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 6.00. To justify a work RVU of 6.00, the RUC compared the survey code to CPT code 37233 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)* (work RVU of 6.50, intra-service time of 60 minutes, total time of 62 minutes) and noted that both services have identical intra-service times and near identical total times. The value for 34711 is lower than the value for 34709 which is a very similar service; however, clinically speaking, the additional endograft extension placed in a delayed fashion for 34711 could be within the previous treatment zone of the initial endograft placement and is therefore less intense then an extension placed at the time of initial endografts deployment. **The RUC recommends a work RVU of 6.00 for CPT code 34711.**

34712 ***Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation***
The RUC reviewed the survey results from 33 physicians and agreed on the following physician time components: 40 minutes for pre-service evaluation time, 20 minutes for pre-service positioning time, 20 minutes for pre-service scrub/dress/wait, 60 minutes for intra-service time, 30 minutes for immediate post-time, 1 99232 visit, 1 99231 visit, 1 99238 discharge visit, 1 99213 office visit and 1 99212 office visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 12.00. To justify a work RVU of 12.00, the RUC compared the survey code to MPC code 54437 *Repair of traumatic corporeal tear(s)* (work RVU of 11.50, intra-service time of 60 minutes, total time of 264 minutes) and noted that both services have identical intra-service times, whereas the survey code involves much more total time, justifying a somewhat higher value for the survey code. **The RUC recommends a work RVU of 12.00 for CPT code 34712.**

34713 ***Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 33 physicians and agreed on the following physician time components: 20 minutes of intra-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the physician work involved in performing this service, with a 25th percentile work RVU of 3.73. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 15152 *Tissue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU of 2.50, intra-service time of 20 minutes) and noted that both services have identical times and involve a very similar amount of physician work. Therefore, the RUC recommends a direct work RVU crosswalk from 15152 to 34713. **The RUC recommends a work RVU of 2.50 for CPT code 34713.**

34812 ***Open femoral artery exposure for delivery of endovascular prosthesis by groin incision, unilateral***
The RUC reviewed the survey results from 34 physicians and agreed on the following physician time components: 40 minutes of intra-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 4.13. To justify a work RVU of 4.13, the RUC compared the survey code to top key reference code 35600 *Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)* (work RVU of 4.94, intra-service time of 40 minutes) and noted that both services have identical time components. **The RUC recommends a work RVU of 4.13 for CPT code 34812.**

34714 ***Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 49 physicians and agreed on the following physician time components: 52 minutes of intra-service time. The specialty societies noted that their expert panel determined and the RUC agreed that there should be a 12 minute increment between 34812 and 34714 to account for the additional work for the conduit, which is a reduction of 8 minutes relative to the survey median. The specialty societies noted that the incremental increase in work RVU and intra-service time would have a similar intensity relative to CPT code 33987 *Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)* (work RVU = 4.04), supporting their expert panel recommendation.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 5.25. To justify a work RVU of 5.25, the RUC compared the survey code to CPT code 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)* (work RVU of 6.50, intra-service time of 45 minutes, total time of 50 minutes) and noted that although the survey code has more intra-service and total time, the reference code involves slightly more intense physician work. **The RUC recommends a work RVU of 5.25 for CPT code 34714.**

34820 ***Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 34 physicians and agreed on the following physician time components: 60 minutes of intra-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 7.00. To justify a work RVU of 7.00, the RUC compared the survey code to CPT code 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)* (work RVU of 8.00, intra-service time of 60 minutes) and noted that both services have identical intra-service time. **The RUC recommends a work RVU of 7.00 for CPT code 34820.**

34833 ***Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 47 physicians and agreed on the following physician time components: 72 minutes of intra-service time. The specialty societies noted that their expert panel determined and the RUC agreed that there should be a 12 minute increment between 34833

and 34820 to account for the additional work for the conduit, which is an increase of 12 minutes relative to the survey median. The specialty societies noted that the incremental increase in work RVU and intra-service time would have a similar intensity relative to CPT code 33987 *Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)*, supporting their expert panel recommendation.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat undervalued the physician work involved in performing this service, with a 25th percentile work RVU of 8.00. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 22634 *Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace and segment (List separately in addition to code for primary procedure)* (work RVU of 8.16, intra-service time of 70 minutes) and noted that both services have very similar intra-service times and involve a similar amount of physician work. Therefore, the RUC recommends a direct work RVU crosswalk from 22634 to 34833.**The RUC recommends a work RVU of 8.16 for CPT code 34833.**

34834 ***Open brachial artery exposure for delivery of endovascular prosthesis unilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 34 physicians and agreed on the following physician time components: 30 minutes of intra-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the physician work involved in performing this service, with a 25th percentile work RVU of 4.00. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU of 2.65, intra-service time of 30 minutes) Therefore, the RUC recommends a direct work RVU crosswalk from 36476 to 34834. **The RUC recommends a work RVU of 2.65 for CPT code 34834.**

34715 ***Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 34 physicians and agreed on the following physician time components: 60 minutes of intra-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 6.00. To justify a work RVU of 6.00, the RUC compared the survey code to CPT code 37233 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)* (work RVU of 6.50, intra-service time of 60 minutes, total time of 62 minutes) and noted that both services have identical intra-service times and near identical total times. **The RUC recommends a work RVU of 6.00 for CPT code 34715.**

34716 ***Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 49 physicians and agreed on the following physician time components: 72 minutes of intra-service time. The specialty societies noted that their expert panel determined and the RUC agreed that there should be a 12 minute increment between 34715 and 34716 to account for the additional work for the conduit, which is an increase of 12 minutes relative to the survey median. The specialtysocieties noted that the incremental increase in work RVU and intra-service time would have a similar intensity relative to CPT code 33987 *Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)*, supporting their expert panel recommendation.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat undervalued the physician work involved in performing this service, with a 25th percentile work RVU of 7.00. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 35682 *Bypass graft; autogenous composite, 2 segments of veins from 2 locations (List separately in addition to code for primary procedure)* (work RVU of 7.19, intra-service time of 78 minutes), and noted that although the survey code has somewhat less intra-service time, it has somewhat more intense physician work and involves a similar total amount of total physician work compared to the reference code. Therefore, the RUC recommends a direct work RVU crosswalk from 35682 to 34716.**The RUC recommends a work RVU of 7.19 for CPT code 34716.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs as approved by the Practice Expense Subcommittee. The 090-day services codes included the standard 090-day clinical labor pre-service times, except for the appropriate reductions for the ruptured emergent services (34702, 34704, 34706 and 34708).

Work Neutrality
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Do Not Use to Validate for Physician Work
The RUC agreed that CPT codes 34702 should be labeled in the RUC database with a flag that it should not be used to validate physician work. The service is projected to have a very low volume and the median survey performance rate for these services was zero times per year.

Treatment of Incompetent Veins (Tab 11)
Matthew Sideman, MD (SVS); Robert Zwolak, MD (SVS); Fran Aiello, MD (SVS); Michael Hall, MD (SIR); Jerry Niedzwiecki, MD (SIR); Curtis Anderson, MD (SIR) Richard White, MD (ACC); Clifford Kavinsky, MD (SCAI); Charles Mabry, MD (ACS); Neil Khilnani, MD (ACPh)

In September 2016, the CPT Editorial Panel created four new Category I codes, revised codes 36468, 36470, and 36471, and revised the guidelines and instructions for reporting treatment for incompetent veins, including deletion of parenthetical notes and guidelines.

36468 ***Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk***
CPT code 36468 was revised at the September 2016 CPT Editorial Panel meeting. The specialty societies indicated that this service contractor priced and restricted by Medicare and they did not conduct a survey. **The RUC does not have a recommendation for CPT code 36468.**

36470 ***Injection of sclerosant; single incompetent vein (other than telangiectasia)***
The RUC reviewed the survey results from 57 physicians and determined that the survey 25th percentile work RVU of 0.75 appropriately accounts for the work required to perform this service. The RUC recommends 9 minutes pre-service evaluation time, 1 pre-service minute scrub/dress/wait time, 15 minutes pre-service intra-service time and 5 minutes immediate post service time. The RUC indicated that 2 minutes were added to pre-evaluation time for preparation of sclerosant and to mark the site for injection and 1 minute subtracted from scrub/dress/wait time because there is no local anesthesia but added 1 minute back to scrub hands and put on sterile gloves.

The RUC noted that this service was changed from a 010-day global period to a 000-day global period to provide consistency within the family of treatment for venous insufficiency. During pre-facilitation the RUC noted that the survey respondents indicated that the physician intra-service time is the same, however, the work of the post-operative 99212 office visit is no longer included. Therefore, the specialty societies indicated that the survey 25th percentile work RVU of 0.75 appropriately decreases the work RVU for the post-operative visit that is no longer included in the global period for this service. The RUC compared the surveyed code to the second top key reference service 20612 *Aspiration and/or injection of ganglion cyst(s) any location* (work RVU = 0.70 and 5 minutes intra-service time) and determined that the surveyed service required more physician time and work and was indicated as more intense and complex on all measures examined. For additional support, the RUC referenced MPC codes 23350 *Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography* (work RVU = 1.00 and 15 minutes intra-service time) and 12013 *Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography* (work RVU = 1.22 and 15 minutes intra-service time) and noted that the MPC codes require the same intra-service time but are more intense. **The RUC recommends a work RVU of 0.75 for CPT code 36470.**

36471 ***Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg***
The RUC reviewed the survey results from 57 physicians and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends 12 minutes pre-service evaluation time, 1 pre-service minute scrub/dress/wait time, 30 minutes intra-service time and 10 minutes immediate post service time. The RUC indicated that 5 minutes were added to pre-evaluation time for preparation of sclerosant and to mark all sites for injection and 1 minute subtracted from scrub/dress/wait time because there is no local anesthesia but added 1 minute back to scrub hands and put on sterile gloves.

The RUC noted that this service was changed from a 010-day global period to a 000-day global period to provide consistency within the family of treatment for venous insufficiency. During pre-facilitation the RUC noted that the survey respondents indicated that the physician intra-service time is the same, however, the work of the post-operative 99212 office visit is no longer included. Therefore, the specialty societies indicated that the survey 25th percentile work RVU of 1.50 appropriately decreases the work RVU for the post-operative visit that is no longer included in the global period for this service. The RUC compared the surveyed code to the second top key reference service 49185 *Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed* (work RVU = 2.35 and 30 minutes intra-service time) and determined that this service

required more total time (67 minutes versus 53) and work to perform. For additional support the RUC referenced MPC code 32405 *Biopsy, lung or mediastinum, percutaneous needle* (work RVU = 1.68 and 30 minutes intra-service time) and noted that this code requires more total time (75 minutes versus 53) and work. **The RUC recommends a work RVU of 1.50 for CPT code 36471.**

36465 ***Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)***
The RUC reviewed the survey results from 53 physicians and determined that the survey 25th percentile work RVU of 2.35 appropriately accounts for the work required to perform this service. The RUC recommends 17 minutes pre-service evaluation time, 4 minutes pre-service positioning, 10 minutes pre-service scrub/dress/wait time, 25 minutes intra-service time and 10 minutes immediate post service time. The RUC indicated that 3 minutes were added to positioning time to adequately adjust the patient's extremity for access to the saphenous vein and 5 minutes added to the scrub/dress/wait time as a sterile operating room technique is maintained for this procedure when performed in an office procedure/surgery suite, which requires scrubbing and sterile gown, mask and gloves for the physician and clinical staff. The RUC noted that these same pre-time adjustments were recommended for 36473 (MOCA) in January 2015 and were accepted by the RUC and CMS.

The RUC pre-facilitation reviewers commented that the specialty societies proposed the same work RVU as code 36482 however 36465 requires 10 minutes less intra-service time. Therefore, the specialty society amended its recommendation to the survey 25th percentile work RVU of 2.35. The RUC compared the surveyed code to the top key reference service 49185 *Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed* (work RVU = 2.35 and 30 minutes intra-service time) and these service require the same physician work and total time (66 versus 67 minutes) to perform. For additional support the RUC referenced MPC codes 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.78 and 30 minutes intra-service time) and 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90 and 15 minutes intra-service time) and noted these services appropriately bracket the surveyed service and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 2.35 for CPT code 36465.**

36466 ***Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg***
The RUC reviewed the survey results from 49 physicians and determined that the survey 25th percentile work RVU of 3.00 appropriately accounts for the work required to perform this service. The RUC recommends 17 minutes pre-service evaluation time, 4 minutes pre-service positioning, 10 minutes pre-service scrub/dress/wait time, 35 minutes intra-service time and 10 minutes immediate post service time. The RUC indicated that 3 minutes were added to positioning time to adequately adjust the patient for access to the saphenous vein and 5 minutes added to the scrub/dress/wait time as a sterile operating room technique is maintained for this procedure when performed in an office procedure/surgery suite, which requires scrubbing and sterile gown, mask and gloves for the physician and clinical staff. The RUC noted that these same pre-time adjustments were recommended for 36473 (MOCA) in January 2015 and were accepted by the RUC and CMS.

The RUC pre-facilitation reviewers commented that original specialty societies proposed recommendation of median work RVU of 4.00 resulted in a higher intensity and the initial proposed increment between 36465 and 36466 was not adequate, therefore the specialty adjusted the recommendation to the survey 25th percentile work RVU of 3.00.The RUC noted that although 36466 and 36482 require similar physician time to complete, 36466 is slightly less intense than 36482 because 36482 typically requires manipulation of a long catheter from the puncture site to the termination of the vein to be treated, while 364C6 does not include this more intense and complex step. In addition, the total time of 36482 is 5 minutes longer than 36466. The RUC compared the surveyed code to the top key reference service 49185 *Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed* (work RVU = 2.35 and 30 minutes intra-service time) noted that the surveyed code requires 5 more minutes of intra-service time and is more intense and complex on all but one of the measures surveyed. For additional support the RUC referenced MPC codes 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.78 and 30 minutes intra-service time) and 52441 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant* (work RVU = 4.50 and 30 minutes intra-service time) and noted these services appropriately bracket the surveyed code and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 3.00 for CPT code 36466.**

36482 ***Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated***

The RUC reviewed the survey results from 35 physicians and determined that the survey 25th percentile work RVU of 3.50 appropriately accounts for the work required to perform this service. The RUC recommends 17 minutes pre-service evaluation time, 4 minutes pre-service positioning, 10 minutes pre-service scrub/dress/wait time, 35 minutes intra-service time and 15 minutes immediate post service time. The RUC indicated that 3 minutes were added to positioning time to adequately adjust the patient's extremity for access to the saphenous vein and 5 minutes added to the scrub/dress/wait time as a sterile operating room technique is maintained for this procedure when performed in an office procedure/surgery suite, which requires scrubbing and sterile gown, mask and gloves for the physician and clinical staff. The RUC noted that these same pre-time adjustments were recommended for 36473 (MOCA) in January 2015 and were accepted by the RUC and CMS.

The RUC noted that although 36466 and 36482 require similar physician time to complete, 36466 is slightly less intense than 36482 because 36482 typically requires manipulation of a long catheter from the puncture site to the termination of the vein to be treated, while 36466 does not include this more intense and complex step. In addition, the total time of 36482 is 5 minutes longer than 36466. The RUC compared the surveyed code to a similar service that was recently reviewed, code 36473 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated* (work RVU = 3.50 and 30 minutes intra-service time) and noted that these service require the same physician work. For additional support the RUC referenced MPC code 52441 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant* (work RVU = 4.50 and 30 minutes intra-service time) and noted that this service demonstrates the appropriate cross specialty relativity. **The RUC recommends a work RVU of 3.50 for CPT code 36482.**

36483 ***Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 30 physicians and surgeons and determined that the survey 25th percentile work RVU of 2.14 was too high and instead recommends a work RVU of 1.75. The specialty societies indicated and the RUC agreed that the work of this add-on is half of that of the base code 36482 (recommended work RVU = 3.50). The RUC recommends 20 minutes of intra-service time for 36483. The RUC notes when CMS finalized the values for MOCA codes 36473 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated* (work RVU = 3.50) and 36474 (work RVU = 1.75) *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure),* CMS did not accept the RUC recommended work RVU for 36474 but instead applied a 50 percent reduction to the work RVU for 36473. The RUC recommends the same value for 36483 as the MOCA add-on 36474.

The RUC compared the surveyed add-on code to MPC codes 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.20 and 15 minutes intra-service time) and 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.25 and 30 minutes intra-service time) and noted these services appropriately bracket the surveyed service and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 1.75 for CPT code 36483.**

Affirmation of RUC Recommendations
The RUC affirmed the recent RUC recommendations for CPT codes 36473, 36475, 36476, 36478 and 36479 previously submitted after review in this coding cycle. The relativity within the family remains correct.

Practice Expense
The Practice Expense Subcommittee made minor modifications to the direct practice expense inputs removing 2 minutes of clinical staff time to *Set-up scope* for CPT codes 36470 and 36471. The Subcommittee maintained 2 minutes to *Set-up scope* for CPT codes 36482, 36465, 36466, which is a proxy to set-up the ultrasound equipment. The PE Subcommittee discussed the number of clinical staff needed to assist the physician with this service and agreed with the specialty societies that the standard for an additional circulator used in interventional radiology services apply to these codes. The standard includes one staff to assist the physician and a separate staff represented by two clinical staff types to act as a circulator. For these services it is an RN/LPN (L042A), "hip to hip" with the physician to assist during the procedure and a vascular technologist, L054A (75%) and a RN/LPN/MTA, L037D (25%) to circulate. The RUC noted that the specialty is requesting new high priced supply items and noted 0.33 of a vial of the new foam supply item is used for the procedure for CPT codes 36465 and 36466. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

New Technology
CPT codes 36482, 36483, 36465 and 36466 will be placed on the New Technology list to be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Therapeutic Apheresis (Tab 12)
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In the Proposed Rule for 2016, CPT code 36516 was nominated for review as potentially misvalued. The nominator stated that the code is misvalued because of incorrect direct and indirect practice expense (PE) inputs and an incorrect work RVU. In the Final Rule for CY 2016, CMS continued the desire for specific review of 36516. At the April 2016 RUC meeting, therapeutic apheresis code 36516 was discussed. During the discussion, the Renal Physicians Association (RPA) and the College of American Pathologists (CAP) indicated there is a concern that the service is misplaced within the CPT coding structure and this misplacement may have resulted in recent inaccuracy of coding. Specifically, the service is an extracorporeal therapy that is more akin to dialysis services (CPT codes 90935-90999) than to surgical procedures, and the code may need to reside in the 909XX series of codes within the CPT coding structure. The two specialties indicated they would submit a code change proposal that will address CPT code 36516 as well as any others in the coding family that may be impacted by a change. The RUC referred CPT code 36516 to the CPT Editorial Panel.

In September 2016, the CPT Editorial Panel deleted 36515 and revised 36516 to included immunoabsorption. CPT codes 36511-36514 and 36522 were added as part of this family of services.

Compelling Evidence
The specialty societies presented compelling evidence for CPT codes 36511-36514, 36516, and 36522. The specialty societies noted that the current work RVUs undervalue these services, which are supported by the results of the survey. The specialty societies provided evidence that incorrect assumptions were made in the previous valuation of all of these services. The previous survey in 2002 was conducted by two specialties (hematology and nephrology) to obtain the values of 36511-36516, but pathologists were not included in this survey. At that time, pathology was the dominant provider for CPT codes 36511, 36512, and a dominant provider for CPT codes 36514, 36516, and 36522, and in 2015 pathology was the dominant provider for CPT codes 36511, 36512, 36514, 36516, and 36522. The specialties added that Pathology's exclusion from the original survey also led to the creation of new vignettes, which were not updated since 2002.

Furthermore, CPT code 36522 has never gone through the RUC process for the valuation of physician work. The work RVU and its time components were determined through the Harvard studies. The dominant provider in 2002 was dermatology. In 2015, the dominant provider was pathology. For code 36522, the specialties noted that the patient population has changed since the code was originally valued. When this was originally valued by the Harvard study, the patients typically had mycosis fungoides; currently, these are bone marrow transplant patients who have graft versus host disease.

The RUC accepted that there is compelling evidence based on the change in dominant provider 36511-36522 and also based on a change in patient population for code 36522.

36511 ***Therapeutic apheresis; for white blood cells***
The RUC reviewed the survey results from 59 physicians and agreed with the following physician time components: pre-service time of 40 minutes, intra-service time of 30 minutes, and post-service time of 15 minutes. The specialty societies indicated that the survey respondents overestimated the pre-service time. Therefore, the specialty societies requested and the RUC agreed to maintain the pre-service time at 40 minutes as nothing changed to justify an increase.
For CPT code 36512, the red blood cell apheresis physician workload intra-service time is slightly less in comparison to CPT codes 36511 and 36513 because the procedure runs slightly quicker for red blood cell exchanges than for white blood cells. However, the physician workload intensity for red blood cell exchange is slightly more than that for white blood cell and platelet depletion apheresis because the infusion of replacement packed red blood cells back into a patient is associated with a higher risk for a transfusion reaction.

The RUC reviewed the 25th percentile work RVU of 2.00 and agreed that this value appropriately accounts for the physician work involved. The specialty society noted that incorrect assumptions were made in the previous valuation of all of these services. To justify a work RVU of 2.00, the RUC compared the survey code to top key reference code 90947 *Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription* (work RVU= 2.52, intra-service time of 50 minutes, and total time of 70 minutes) and noted that although the reference code includes more intra-service time, the survey code includes more total time. The RUC noted that 96 percent of the survey respondents that selected 90947 as a key reference indicated that the surveyed code is more intense, supporting the work RVU of the survey code at 2.00 RVUs. To further justify the work RVU, the RUC compared the survey code to CPT code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family* (work RVU= 3.17, intra-service time of 45 minutes, and total time of 67 minutes) and agreed that the survey code has more total time and that the survey respondents indicated that the survey code involves more intense physician work, supporting the work RVU of the survey code at 2.00. **The RUC recommends a work RVU of 2.00 for CPT code 36511.**

36512 ***Therapeutic apheresis; for red blood cells***
The RUC reviewed the survey results from 62 physicians and agreed with the following physician time components: pre-service time of 40 minutes, intra-service time of 20 minutes, and post-service time of 15 minutes. The specialty societies indicated that the survey respondents overestimated the pre-service time. Therefore, the specialty societies requested and the RUC agreed to maintain the pre-service time at 40 minutes as nothing changed to justify an increase.

For CPT code 36512, the red blood cell apheresis physician workload intra-service time is slightly less in comparison to CPT codes 36511 and 36513 because the procedure runs slightly quicker for red blood cell exchanges than for white blood cells. However, the physician workload intensity for red blood cell exchange is slightly more than that for white blood cell and platelet depletion apheresis because the infusion of replacement packed red blood cells back into a patient is associated with a higher risk for a transfusion reaction.

The RUC reviewed the 25th percentile work RVU of 2.00 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 2.00, the RUC compared the

survey code to CPT code 19283 *Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance* (work RVU= 2.00, intra-service time of 20 minutes, post-service time of 15 minutes, and total time of 57 minutes) and noted that both codes have identical intra-service times and involve a similar amount of physician work, supporting the work RVU of the survey code at 2.00. To further justify the work RVU, the RUC compared the survey code to CPT code 45337 *Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed* (work RVU= 2.10, intra-service time of 25 minutes, and total time of 68 minutes) and noted that both services have similar work RVUs, intra-service times, and total times, supporting the work RVU of the survey code at 2.00. **The RUC recommends a work RVU of 2.00 for CPT code 36512.**

36513 ***Therapeutic apheresis; for platelets***
The RUC reviewed the survey results from 36 physicians and agreed with the following physician time components: pre-service time of 40 minutes, intra-service time of 25 minutes, and the existing post-time of 15 minutes. The specialty societies indicated that the survey respondents overestimated the pre-service time. Therefore, the specialty societies requested and the RUC agreed to maintain the pre-service time at 40 minutes as nothing changed to justify an increase.

For CPT code 36512, the red blood cell apheresis physician workload intra-service time is slightly less in comparison to CPT codes 36511 and 36513 because the procedure runs slightly quicker for red blood cell exchanges than for white blood cells. However, the physician workload intensity for red blood cell exchange is slightly more than that for white blood cell and platelet depletion apheresis because the infusion of replacement packed red blood cells back into a patient is associated with a higher risk for a transfusion reaction.

The RUC reviewed the 25th percentile work RVU of 2.00 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 2.00, the RUC compared the survey code to CPT code 19283 *Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance* (work RVU= 2.00, intra-service time of 20 minutes, post-service time of 15 minutes, and total time of 57 minutes) and noted that both codes have similar intra-service times, identical post-service times, and involve a similar amount of physician work, supporting the work RVU of the survey code at 2.00 RVUs. To further justify the work RVU, the RUC compared the survey code to CPT code 36002 *Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm* (work RVU= 1.96, intra-service time of 30 minutes, post-time of 15 minutes, and total time of 80 minutes) and noted that both services have similar intra-services times, identical post-times and total-times. **The RUC recommends a work RVU of 2.00 for CPT code 36513.**

36514 ***Therapeutic apheresis; for plasma pheresis***
The RUC reviewed the survey results from 69 physicians and agreed with the following physician time components: pre-service time of 29 minutes, intra-service time of 20 minutes, and post-time of 15 minutes.

The RUC reviewed the 25th percentile work RVU of 2.00 and agreed that the survey respondents overvalued the physician work involved in performing this service. To find an appropriate work RVU crosswalk for CPT code 36514, the RUC compared the survey code to CPT code 64446 *Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)* (work RVU= 1.81, intra-service time of 20 minutes, and total time of 64 minutes) and noted that both services had identical intra-service times of 20 minutes and involve a similar amount of physician work. Therefore, the RUC recommends a direct RVU crosswalk from code 64446 to 36514. To further support a work RVU of 1.81, the RUC compared the survey code to CPT code

64416 *Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)* (work RVU= 1.81, intra-service time of 20 minutes, and total time of 60 minutes) and CPT code 45990 *Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic* (work RVU= 1.80, intra-service time of 20 minutes, and total time of 95 minutes) and noted that both services had similar intra-service times and 64416 has a similar total time, supporting the work RVU of the survey code at 1.81. **The RUC recommends a work RVU of 1.81 for CPT code 36514.**

36516 ***Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion***

The RUC reviewed the survey results from 35 physicians and agreed with the following physician time components: pre-service time of 25 minutes, intra-service time of 15 minutes, and post-time of 10 minutes. The pre-service time was cross walked from existing pre-times for this code. The specialty societies indicated that the survey respondents overestimated the pre-service time. Therefore, the specialty societies requested and the RUC agreed to maintain the pre-service time at 25 minutes as nothing changed to justify an increase.

The RUC reviewed the 25th percentile work RVU of 1.56 and agreed that this value appropriately accounts for the physician work involved. To compare the relativity of other services, the RUC assimilated the overall work of CPT code 90945 *Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional* (work RVU= 1.56, total time of 47 minutes) to 36516. The RUC also justified a work RVU of 1.56, by comparing the survey code to CPT code 45333 *Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps* (work RVU= 1.55, intra-service time of 15 minutes, post-time of 10 minutes, and total time of 47 minutes) and noted that both services had identical intra-service and post-times, and similar total time, supporting the work RVU of the survey code at 1.56 RVUs. To further justify the work RVU, the RUC compared the survey code to CPT code 44386 *Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple* (work RVU= 1.50, intra-service time of 17 minutes, post-time of 10 minutes, and total time of 49 minutes) and noted that both services had similar intra-service times, identical post-times, and similar total times, further supporting the work RVU of the survey code. **The RUC recommends a work RVU of 1.56 for CPT code 36516.**

36522 ***Photopheresis, extracorporeal***

The RUC reviewed the survey results from 36 physicians and agreed on the following physician time components: pre-service time of 33 minutes, intra-service time of 18 minutes, and post-time of 10 minutes. The pre-service time was cross walked from CPT code 50387.

The RUC reviewed the 25th percentile work RVU of 1.50 and agreed that this undervalued the physician work involved. To find an appropriate work RVU crosswalk for CPT code 36522, the RUC compared the survey code to CPT code 50387 *Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation.* CPT code 50387 was last reviewed by the RUC in April 2005, and for CY 2017 CMS extracted the physician work and time of moderate sedation from this procedure which reduced the work RVU from 2.00 to 1.75 and reduced the pre-service time from 38 minutes to 33. The intra-service time and post-service times are identical to the surveyed code, 18 minutes and 10 minutes respectively. The RUC determined that the overall physician work of CPT code 50387 is identical to 36522 by the multispecialty expert panel and the RUC. **The RUC recommends a work RVU of 1.75 for CPT code 36522.**

Practice Expense
The PE Subcommittee discussed the direct practice expense inputs proposed by the specialty societies and determined that there was duplication between the clinical staff tasks of the pre-service period and the pre-service portion of the service period. The Subcommittee reduced the pre-service time from 18 to 8 minutes. The Subcommittee discussed the significant time needed for the staff to *Assist physician in performing procedure* in the service period and agreed with the specialties that this service is one-on-one with the patient and the RN/LPN (L042A) is not able to multitask during this time. The Subcommittee discussed the significant time needed to prepare the room, equipment, and supplies. The specialties explained that the clinical staff time hadn't been accurately accounted for when it was last reviewed in 2004. The PE Subcommittee also discussed that much of the time requested in the post-service time was duplicative of the monitoring time and removed most of that time while maintaining the specialty recommended 10 minutes for monitoring in the service period. Additionally the PE Subcommittee reduced the time for *Clean room/equipment by physician staff; remove disposables from machine* from 7 in 36514 and 36516 and 5 in 36522 to the standard 3. The Subcommittee discussed the possibility that some of the supply items are separately reportable. The Subcommittee found that *albumin saline* (SH004) which is 5% albumin is separately reportable and new supply item *calcium gluconate* is separately reportable with J code J0610 per 10 ml for the drug along with CPT code 96365 to mix the bag. **The Subcommittee deleted the two supply items and recommends that the specialty societies prepare a CPT assistant article regarding how to report separately for these supplies.** The RUC reviewed and approved the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

Referral to the CPT Editorial Panel
During the RUC's discussion, an issue was raised regarding miscoding for code 36513 *Therapeutic apheresis; for platelets*. The RUC noted and the specialties concurred that this code is only intended for therapeutic platelet depletion. The 2015 Medicare Claims data suggested that there was a portion of claims with miscoding. When platelets are harvested for other purposes (i.e. for donor collections), it would be inappropriate to use 36513. The RUC refers this issue to the CPT Editorial Panel for consideration of changes to the coding language to prevent the miscoding (i.e. a parenthetical or changes to the introductory language). The RUC noted that the following clinical vignette, which was used to value this service, was appropriate and that 94 percent of respondents had found the vignette to be typical: "A 65 year old man with essential thrombocythemia presents with a markedly elevated platelet count and mental status changes, consistent with poor brain perfusion. Emergent reduction of his platelet count is indicated."

<u>Peri-Prostatic Implantation of Biodegradable Material (Tab 13)</u>
Thomas Turk, MD (AUA); James Depree, MD (AUA); Michael Kuettel, MD, PhD (ASTRO); David Beyer, MD (ASTRO); Gerald White (ASRO)

In October 2016, the CPT Editorial Panel deleted CPT Category III code 0438T and created a new CPT code 55874 to report transperineal placement of biodegradable material.

55874 ***Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed***
The RUC reviewed the survey results from 175 urologists and radiation oncologists and determined that a work RVU recommendation of 3.03 was appropriate and supported by the 25th percentile of the survey. Of the 175 survey respondents, 65 had performed the procedure in the last year which exceeds the survey threshold; these responses were combined with the 110 other respondents who had not performed the procedure in the last year but likely had contributed to the initial clinical trial. The specialty societies confirmed that the final recommendation of the 25th percentile reflected the combined survey. The specialty societies also clarified that ultrasound is

performed continuously throughout the procedure. Further, they confirmed that the description of intra-service work is correct in that, after the ultrasound probe is placed and anesthesia is conducted, hydrodissection is the initial step in the procedure. Once the hydrodissection is completed, the syringe is removed but the needle is intact; at that time, the biodegradable material is prepped. It is never prepped prior to the procedure but is done after the hydrodissection which is why it is included in the intra-service time.

The RUC recommends 25 minutes pre-service time, 30 minutes intra-service time, and 15 minutes post-service time (total time 70 minutes). The RUC agreed to add five minutes of positioning time above the standard package to account for positioning the patient in the dorsal lithotomy position. The RUC compared the surveyed code to the top key reference service 49411 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple* (work RVU = 3.57, intra-service time of 40 minutes, total time 75 minutes) and noted that both services have similar physician IWPUT (0.074 and 0.071 respectively) with the surveyed code being higher due to the shorter intra-service work time. The RUC noted that the second key reference service 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple,* (work RVU = 1.73 and intra-service time of 20 minutes) requires 10 minutes less intra-service time and is less complex and intense, thus the surveyed code is appropriately valued higher.

For additional support, the RUC compared the surveyed code to CPT code 44389 *Colonoscopy through stoma; with biopsy, single or multiple* (work RVU = 3.02, intra-service time of 30 minutes, total time 65 minutes) and also considered CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU = 3.05, intra-service time of 30 minutes, total time 80 minutes). **The RUC recommends a work RVU of 3.03 for CPT code 55874.**

Practice Expense
Modifications were made to the direct practice expense inputs including substantial decreases in pre-service time. The PE Subcommittee noted that the specialty is requesting a new high priced supply item *Biodegradeable Material Kit – PeriProstatic,* and discussed that if there is an application for this item to be separately billable through a HCPCS code the kit will need to be removed from the direct practice expense inputs. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

New Technology
This service will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Colporrhaphy with Cystourethroscopy (Tab 14)
George Hill, MD, (ACOG); Jon Hathaway, MD, PhD (ACOG); Mitch Schuster, MD (ACOG)
Facilitation Committee #1

In October 2015, CPT code 57240 was identified in which the Medicare data from 2011-2013 indicated that it was performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within the global period. In April 2016, the specialty society indicated they are working with CMS and its contractor NCCI on issues related to the colporrhaphy codes. NCCI instituted edits that prohibit reporting a Cystourethroscopy (CPT code 52000) with these services. NCCI recommended the specialty

society address this issue through the CPT process. The RUC recommended 57240, 57250, 57260 and 57265 be referred to the CPT Editorial Panel. In September 2016, the CPT Editorial Panel revised 57240, 57260 and 57265 to preclude separate reporting of follow up cystourethroscopy after colporrhaphy.

57240 ***Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed***
The RUC reviewed the survey results from 115 physicians and agreed on the following physician time components: 33 minutes of pre-service evaluation time, 8 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, intra-service time of 60 minutes, immediate post-time of 30 minutes, a half-day discharge (99238) and 2 99213 post-op office visits.

The RUC reviewed the survey 25th percentile work RVU of 12.00 and agreed that the survey respondents somewhat overvalued the physician work involved in performing this service. To find an appropriate work RVU crosswalk for CPT code 57240, the RUC compared the surveyed code to MPC code 53850 *Transurethral destruction of prostate tissue; by microwave thermotherapy* (work RVU of 10.08, intra-service time of 60 minutes and total time of 204) and noted that both services involve a similar amount of physician work and have identical intra-service time and similar total time. Therefore, the RUC recommends a direct RVU crosswalk from code 53850 to 57240. The RUC noted that, with this change, the code would have an IWPUT of 0.096, appropriate relative to the top and 2nd key reference codes. To further support the value, the RUC also noted that the proposed value compared favorably to CPT code 19301 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);* (work RVU of 10.13, intra-service time of 60 minutes, total time of 216 minutes). **The RUC recommends a work RVU of 10.08 for CPT code 57240.**

57250 ***Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy***
The RUC reviewed the survey results from 115 physicians and agreed on the following physician time components: 33 minutes of pre-service evaluation time, 8 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, intra-service time of 60 minutes, immediate post-time of 30 minutes, a half-day discharge (99238) and 2 99213 post-op office visits.

The RUC reviewed the survey 25th percentile work RVU of 11.50 and agreed that the survey respondents somewhat overvalued the physician work involved in performing this service. To find an appropriate work RVU crosswalk for CPT code 57250, the RUC compared the survey code to MPC code 53850 *Transurethral destruction of prostate tissue; by microwave thermotherapy* (work RVU of 10.08, intra-service time of 60 minutes and total time of 204) and noted that both services involve a similar amount of physician work and have identical intra-service time and similar total time. Therefore, the RUC recommends a direct RVU crosswalk from code 53850 to 57250. The RUC noted that, with this change, the code would have an IWPUT of 0.096, appropriate relative to the top and 2nd key reference codes. To further support the value, the RUC also noted that the proposed value compared favorably to CPT code 19301 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);* (work RVU of 10.13, intra-service time of 60 minutes, total time of 216 minutes). **The RUC recommends a work RVU of 10.08 for CPT code 57250.**

57260 ***Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;***
The RUC reviewed the survey results from 115 physicians and agreed on the following physician time components: 33 minutes of pre-service evaluation time, 8 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, intra-service time of 90 minutes, immediate post-time of 30 minutes, a half-day discharge (99238) and 2 99213 post-op office visits.

The RUC reviewed the survey 25th percentile work RVU of 13.25 and agreed that the survey respondents correctly valued the physician work involved in performing this service. To justify a work RVU of 13.25, the RUC compared the survey code to top key reference code 58570 *Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;* (work RVU of 13.36, intra-service time of 90 minutes and total time of 241 minutes) and noted that both services have identical intra-service and total times and both are typically performed in the outpatient setting. To further support a value of 13.25, the RUC compared the surveyed code to CPT Code 58571 *Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)* (work RVU of 15.00, intra-service time of 90 minutes, total time of 241 minutes) and noted that both services have identical time components and identical post-op visit components. Both services are typically performed in the hospital outpatient setting, while the reference code involves somewhat more intense intra-service work though supports a value of 13.25 for the survey code. The RUC confirmed that the specialty's original recommendation of 13.25 is appropriate relative to the recommended values for 57240 and 57250. **The RUC recommends a work RVU of 13.25 for CPT code 57260.**

57265 ***Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair***

The RUC reviewed the survey results from 114 physicians and agreed on the following physician time components: 33 minutes of pre-service evaluation time, 8 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, intra-service time of 120 minutes, immediate post-time of 30 minutes, a half-day discharge (99238) and 2 99213 post-op office visits.

The RUC reviewed the survey 25th percentile work RVU of 15.00 and agreed that the survey respondents correctly valued the physician work involved in performing this service. To justify a work RVU of 15.00, the RUC compared the survey code to CPT code 58544 *Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)* (work RVU of 15.60, intra-service time of 120 minutes and total time of 271 minutes) and noted that both services have identical intra-service and total times and are both typically performed in the outpatient setting. To further support a work RVU of 15.00, the RUC compared the survey code to top key reference code 58572 *Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;* (work RVU 17.71, intra-service time of 120 minutes and total time of 271 minutes) and noted that both services have identical time components and identical post-op visit components. Both services are typically performed in the hospital outpatient setting, while the reference code involves somewhat more intense intra-service work though supports a value of 15.00 for the survey code. The RUC confirmed that the specialty's original recommendation of 15.00 is appropriate relative to the recommended values for the other codes in the family. **The RUC recommends a work RVU of 15.00 for CPT code 57265.**

Practice Expense

The RUC reviewed and approved the direct practice expense inputs as approved without modification by the Practice Expense Subcommittee.

Work Neutrality

The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Percutaneous Neurostimulator Placement (Tab 15)
Norm Smith, MD (AUA); Philip Wise, MD (AUA); George Hill, MD (ACOG)

In the Proposed Rule for 2015, a stakeholder raised questions regarding whether codes 64553 and 64555 include the appropriate direct PE inputs when furnished in the non-facility setting. It appears that these inputs have not been evaluated recently and therefore CMS are nominating these codes as potentially misvalued for the purpose of ascertaining whether or not there are non-facility direct PE inputs that are not included in the direct PE inputs that are typical supply costs for these services.

The RUC reviewed the practice expense only in January 2015. In the Final Rule for 2015 CMS requested that the work and PE be reviewed. In April 2015, the RUC discussed the confusion that survey respondents experienced valuing this service. The description only states the nerve that the neurostimulator is implanted in, and most respondents completed the survey as if it is performed in the facility setting. The Medicare data conflicts with this site of service, reporting that 65% of the time this service is performed in the physician's office. Additionally the supplies and equipment may be different for the temporary and permanent implantation. The RUC recommended referring CPT code 64553 to the CPT Editorial Panel to better define this service, such as having one code to describe temporary or testing implantation and another code to describe permanent implantation. The RUC recognized that it needed to establish an interim value for 64553 until this service could be clarified by CPT. The RUC recommended maintaining the current work value of 2.36 as interim for CPT code 64553 and referral to the CPT Editorial Panel. In May 2016 CPT postponed this tab to rework for September 2016.

In September 2016, the CPT Editorial Panel deleted code 64565 to report percutaneous placement of a neuromuscular neurostimulator electrode, and added parenthetical notes to direct users to report the appropriate codes for TENS, PENS, and PNT services throughout the family of codes.

Compelling Evidence
The specialty societies presented compelling evidence for CPT codes 64553 and 64555. The surveying specialty societies agree that codes 64553 and 64555 are undervalued and presented the following compelling evidence as support. CPT codes 64553 and 64555 as originally described and valued by the Harvard study were very different procedures than they are today. The current generation of implants did not exist when these codes were first considered so, the specialties noted, this survey represents the first true data regarding the work of the modern procedure. The old testing procedure was similar to using a stimulating needle for nerve localization for a peripheral nerve block which takes less time, less clinical expertise and less training than the current procedure. The specialties also explained that imaging guidance was not typical and the type of nerves that could be targeted was limited by anatomic considerations (e.g., easily accessible, ability to visualize directly). The leads at that time were also very simple, often with only one or two electrical contacts. Codes 64553 and 64555, as originally performed, took much less time and were much less invasive.

The specialty societies noted and the RUC concurred that peripheral neuromodulation today involves a multi-step process, knowledge of advanced technology, and placement of a multi-contact lead with up to 16 contacts adjacent to the length of a nerve (as opposed to just two contacts next to or around a nerve), as well as use of a multi-contact array for multiple anodes/cathodes in a single lead, requiring much more complex programming of these multiple contacts.

Additionally, the patient population has changed as the ability to stimulate and provide better analgesia to cranial and peripheral nerves throughout the nervous system has become possible using the new multi-contact technology. The current patient population is much more complex.

The current procedure is for the treatment of patients with very severe nerve injuries and intractable pain in a variety of nerves. Many of the nerves that are stimulated today were not approachable with previous techniques and equipment. Lastly, the original valuation for 64553 and 64555 was based on responses from a small group of general surgeons and not by physicians who perform these procedures today. The RUC agreed that there is compelling evidence that codes 64553 and 64555 are misvalued based on a change in technology, change in patient population and a flawed original methodology.

64553 ***Percutaneous implantation of neurostimulator electrode array; cranial nerve***
The RUC reviewed the survey results from 30 physicians and agreed with the following physician time components: pre-service evaluation time of 18 minutes, pre-service positioning time of 1 minute, pre service scrub/dress/wait time of 6 minutes, intra-service time of 75 minutes, immediate post-service time of 18 minutes, a half-day discharge visit (99238) and 1 99213 office visit. The RUC noted that the existing physician time from the Harvard study was not valid and that this service had never been evaluated by the RUC in the past.

The RUC reviewed the survey 25th percentile work RVU of 6.13 and agreed that this value appropriately accounts for the physician work involved in performing this service. To justify a work RVU of 6.13, the RUC compared the survey code to top key reference CPT code 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* (work RVU= 7.15, intra-service time of 60 minutes and total time of 170 minutes) and noted that the survey code has more intra-service time and both services have similar physician work intensities, supporting the work RVU of the survey code at 6.13 RVUs. To further justify the work RVU, the RUC compared the survey code to CPT code 62350 *Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy* (work RVU= 6.05, intra-service time of 60 minutes, total time of 170 minutes) and noted that the survey code has more intra-service time and both services have similar physician work intensities. **The RUC recommends a work RVU of 6.13 for CPT code 64553.**

64555 ***Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)***
The RUC reviewed the survey results from 31 physicians and agreed with the following physician time components: pre-service evaluation time of 18 minutes, pre-service positioning time of 1 minute, pre service scrub/dress/wait time of 6 minutes, intra-service time of 60 minutes, immediate post-service time of 18 minutes, a half-day discharge visit (99238) and 1 99213 office visit. The RUC noted that the existing physician time from the Harvard study was not valid and that this service had never been evaluated by the RUC in the past.

The RUC reviewed the survey 25th percentile work RVU of 5.76 and agreed that this value appropriately accounts for the physician work involved in performing this service. To justify a work RVU of 5.76, the RUC compared the survey code to top key reference CPT code 63650 Percutaneous implantation of neurostimulator electrode array, epidural (work RVU= 7.15, intra-service time of 60 minutes and total time of 170 minutes) and noted that both services had identical intra-service times and have similar physician work intensities per the survey respondents, supporting the work RVU of the survey code at 5.76 RVUs. To further justify the work RVU, the RUC compared the survey code to CPT code 62350 *Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy* (work RVU= 6.05, intra-service time of 60 minutes, total time of 170 minutes) and noted that both services have identical intra-service times. **The RUC recommends a work RVU of 5.76 for CPT code 64555.**

64561 ***Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed***
The RUC discussed CPT code 64561, noting that it was last surveyed for the January 2014 RUC meeting. The RUC agreed that the existing RVU and times for this service are appropriate. The dominant specialty for this service, Urology, noted and the RUC agreed that the amount and type of physician work and direct practice expense involved in performing this service has not changed in the past 3 years. In addition, the specialty noted that the physician work on the sacral nerve is not the same as the physician work involved in 64553 and 64555 for cranial nerves. **The RUC affirmed the work RVU of 5.44 for CPT code 64561.**

Practice Expense
The PE Subcommittee approved compelling evidence for the possibility of an increase in the direct practice expense inputs in the nonfacility setting. The Subcommittee only made changes to correct the equipment time formulas consistent with current standards. The RUC reviewed and approved the direct practice expense inputs as approved by the Practice Expense Subcommittee.

Nerve Repair with Nerve Allograft (Tab 16)
Anne Miller-Breslow, MD (ASSH); Mark Villa, MD (ASPS)

The CPT Editorial Panel created two new Category I codes to report the repair of a nerve using a nerve allograft. Codes 64910 and 64911 were added as family codes for review.

64910 ***Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve***
The RUC reviewed the survey results from 63 hand surgeons and plastic surgeons and agreed on the following physician time components: 33 minutes of pre-service evaluation time, 10 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, intra-service time of 75 minutes, immediate post-time of 20 minutes, one-half discharge day management (0.5 x 99238), 3 x 99213 post-op office visits and 1 x 99212 post-op office visit. The specialty societies explained that the 4 post-op office visits include the following physician work: Patient and family questions about surgery outcome and progress are answered. The dressings are removed and the wound is assessed for any signs of infection or edema. The neurovascular status is assessed. The range of motion of the wrist, fingers and thumb are evaluated. The presence of a progressing Tinel's sign is evaluated. Dressings and a splint are reapplied to the wound. At the first visit, a therapy prescription is generated for the fabrication of a custom splint that will protect the nerve repair while allowing gentle protected range of motion of the wrist, fingers and thumb. If necessary an outside therapist will be contacted to discuss the postoperative regimen. At subsequent visits, the interval therapy report is reviewed and signed. Additional therapy recommendations will be prescribed, as appropriate. Sutures will be removed at the second or third visit, as appropriate. Scar control techniques are demonstrated. Pain is assessed at each visit and medication is ordered as necessary. The chart note and letter to the PCP/referring physician are completed at each visit. Disability documentation, if needed, is completed at each visit.

The RUC reviewed the survey 25th percentile work RVU of 10.52 which is less than the current work RVU and agreed that this value correctly accounts for the physician work involved in performing this service. To justify a work RVU of 10.52, the RUC compared the survey code to top key reference code 64831 *Suture of digital nerve, hand or foot; 1 nerve* (work RVU of 9.16, intra-service time of 60 minutes, total time of 237 minutes) and noted that the survey code includes more intra-service and total time. Both services have a near identical IWPUT which is consistent since both services involve a similar intensity of physician work. To further support a work RVU of 10.52, the RUC referenced code 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU = 11.90, intra-time 75 minutes, total time = 233 minutes). **The RUC recommends a work RVU of 10.52 for CPT code 64910.**

64911 ***Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve***
The RUC reviewed the survey results from 35 hand surgeons and plastic surgeons for this rarely performed procedure and agreed on the following physician time components: 33 minutes of pre-service evaluation time, 10 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, intra-service time of 110 minutes, immediate post-time of 20 minutes, one-half discharge day management (0.5 x 99238), 3 x 99213 post-op office visits and 1 x 99212 post-op office visit. The specialty societies explained that the 4 post-op office visits include the following physician work: Patient and family questions about surgery outcome and progress are answered. The dressings are removed and both wounds are assessed for any signs of infection or edema. The neurovascular status is assessed. The range of motion of the wrist, fingers and thumb are evaluated. The presence of a progressing Tinel's sign is evaluated. Dressings are reapplied to both wounds and splint is applied. At the first visit, a therapy prescription is generated for the fabrication of a custom splint that will protect the nerve repair while allowing gentle protected range of motion of the wrist, fingers and thumb. If necessary an outside therapist will be contacted to discuss the postoperative regimen. At subsequent visits, the interval therapy report is reviewed and signed. Additional therapy recommendations will be prescribed, as appropriate. Sutures will be removed at the second or third visit, as appropriate. Scar control techniques are demonstrated. Pain is assessed at each visit and medication is ordered as necessary. The chart note and letter to the PCP/referring physician are completed at each visit. Disability documentation, if needed, is completed at each visit.

The RUC reviewed the survey median work RVU of 14.00 which is less than the current work RVU and agreed that this value correctly accounts for the physician work involved in performing this service. To justify a work RVU of 14.00, the RUC compared the survey code to MPC code 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU of 14.56, intra-service time of 120 minutes, total time of 279 minutes) and noted that although the reference code has more intra-service time, the survey code includes more total time. To further support a work RVU of 14.00, the RUC compared the survey code to CPT code 58543 *Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;* (work RVU of 14.39, intra-service time of 110 minutes, total time of 261 minutes) and noted that both services have identical intra-service time whereas the survey code includes more total time. **The RUC recommends a work RVU of 14.00 for CPT code 64911.**

64912 ***Nerve repair; with nerve allograft, each nerve, first strand (cable)***
The RUC reviewed the survey results from 65 hand surgeons and plastic surgeons and agreed on the following physician time components: 33 minutes of pre-service evaluation time, 10 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, intra-service time of 90 minutes, immediate post-time of 20 minutes, one-half discharge day management (0.5 x 99238), 3 x 99213 post-op office visits and 1 x 99212 post-op office visit. The specialty societies explained that the 4 post-op office visits include the following physician work: Patient and family questions about surgery outcome and progress are answered. The dressings are removed and the wound is assessed for any signs of infection or edema. The neurovascular status is assessed. The range of motion of the wrist, fingers and thumb are evaluated. The presence of a progressing Tinel's sign is evaluated. Dressings and a splint are reapplied. At the first visit, a therapy prescription is generated for the fabrication of a custom splint that will protect the nerve repair while allowing gentle protected range of motion of the wrist, fingers and thumb. If necessary an outside therapist will be contacted to discuss the postoperative regimen. At subsequent visits, the interval therapy report is reviewed and signed. Additional therapy recommendations will be prescribed, as appropriate. Sutures will be removed at the second or third visit, as appropriate. Scar control techniques are demonstrated. Pain is assessed at each visit and medication is ordered as

necessary. The chart note and letter to the PCP/referring physician are completed at each visit. Disability documentation, if needed, is completed at each visit.

The RUC reviewed the survey 25th percentile work RVU of 12.00 and agreed that this value correctly accounts for the physician work involved in performing this service. To justify a work RVU of 12.00, the RUC compared the survey code to MPC code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* (work RVU of 13.00, intra-service time of 90 minutes, total time of 314 minutes) and noted that both services have identical intra-service time whereas the reference code involves somewhat more total time. To further support a work RVU of 12.00, the RUC compare the survey code to MPC code 47563 *Laparoscopy, surgical; cholecystectomy with cholangiography* (work RVU of 11.47, intra-service time of 90 minutes, total time of 238 minutes, and noted that both services have identical intra-service times whereas the survey code includes more total time, and a somewhat higher valuation for the survey code is warranted. **The RUC recommends a work RVU of 12.00 for CPT code 64912.**

64913 ***Nerve repair; with nerve allograft, each additional strand (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 36 hand surgeons and plastic surgeons and agreed on the following physician time components: intra-service time of 30 minutes.

The RUC reviewed the survey 25th percentile work RVU of 3.00 and agreed this value correctly accounts for the physician work involved in performing this service. To justify a work RVU of 3.00, the RUC compared the survey code to CPT code 15157 *Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU of 3.00, intra-service time of 30 minutes) and noted that both services have identical times and involve a similar amount of physician work. To further support a value of 3.00, the RUC compared the survey code to top key reference code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU of 3.73, intra-service time of 40 minutes) and noted that the reference code includes more intra-service time and has a higher work RVU, though 93 percent of survey respondents indicated that the survey code is a more intense service to perform, supporting the somewhat higher IWPUT for the survey code and the recommended work RVU. **The RUC recommends a work RVU of 3.00 for CPT code 64913.**

Practice Expense
The Practice Expense Subcommittee reduced the amount of equipment time for the power table, as the 4th office visit would typically use a chair instead of a table. The Subcommittee also reduced the amount of equipment time for the exam light as it is typically only used for the first two office visits. The RUC reviewed and approved the direct practice expense inputs as modified by the Practice Expense Subcommittee.

New Technology
CPT codes 64912 and 64913 will be placed on the New Technology list to be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Photodynamic Therapy (Tab 17)
Howard Rogers, MD (AAD); Mark Kaufmann, MD (AAD)
Facilitation Committee #3

CPT code 96567 *Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session* was identified by Centers for Medicare and Medicaid Services (CMS) in the high expenditure services screen. The RUC recommended that this service be removed from the screen because the work RVU=0.00. However, in the Final Rule for 2016, CMS indicated that the work and practice expense for this service should be reviewed.

In April 2001 CPT code 96567 was reviewed as new technology. The procedure involves application of a photo-sensitizing agent followed by exposure to special ultra-violet light. A survey of 39 dermatologists using this new technology indicated that there was some physician work for this XXX global period procedure. However, upon review of the survey responses, the specialty society concluded that the respondents did not accurately assess the time required by the physician for this procedure using the new technology and included a written recommendation that for the typical patient receiving this procedure, there is no physician work. The RUC agreed that the procedure, using this new technology, does not involve physician work but does involve practice expense direct inputs. Years later the service was nominated to be considered in 2005 Five-Year Review. The final Five-Year Workgroup report indicated that after extensive discussion with the RUC regarding the potential need for further CPT revisions the RUC advised the specialty society that if physician work is part of the code the specialty would need to submit a coding proposal to CPT to clarify the language to include physician work. At that time the specialty decided to instead withdraw the code from the Five-Year Review.

At the April 2016 RUC meeting the specialty society recommended that the service be deferred to the October 2016 RUC meeting in order for a survey of work to be conducted. The specialty explained that in reviewing the service closely, they realized that there is now physician work involved in providing this service. In order to confirm this observation the specialty conducted an informal survey that was sent to a few dermatologists. The specialty contends that the results confirm that physicians are involved in the actual delivery of care to patients by performing tasks such as: curettage of thick lesions, real time tailoring of the PDT regimen, explaining side effects, and providing post care instructions. A RUC member questioned if any of the aforementioned services were separately reportable and the specialty clarified that they are not. The specialty added that there has been no change to the service and that it is not necessary to refer to the code to the CPT Editorial Panel. A RUC member questioned why the specialty would be claiming that there is physician work now, when it was stated by the specialty that the service has not changed and in 2001 the specialty concluded that for the typical patient there is no physician work as noted above. A RUC member suggested that there may be the need for two separate codes, one for a simple procedure that clinical staff can provide and one that is more complex and needs physician involvement. Another RUC member stated that we do not have enough information to determine if the service should or should not be submitted to CPT and ultimately that decision is up to the specialty society. The RUC member continued that this is an unusual service in that it usually is a two encounter service yet it is a single XXX global code. If they are going to survey for work, it is advisable to go to CPT in order to separate this into two codes or at a minimum seek advice from the Research Subcommittee about how to survey for this type of service. The specialty indicated that it would submit a code change application to split code 96567 into two codes—one to describe physician work and one to describe the technical component. The RUC referred CPT code 96567 to the CPT Editorial Panel.

In September 2016, the CPT Editorial Panel deleted code 96567 and created two new codes to describe physician identification of debridement and hyperkeratotic lesions and physician application of a photosensitizing agent.

Compelling Evidence
The specialty societies presented compelling evidence for codes 96573 and 96574. The specialty explained that the concept of the old code where the clinical staff blindly applies photosensitizer one day and then shines the photosensitizer light on it the next day is obsolete. Photodynamic therapy has evolved with more aggressive skin preparation, customized multilayer application of photosensitizer by the physician and occlusion during incubation has changed the procedure from being a two day procedure to a one day procedure with increased efficacy and decreased side effects. As it is done now, the application is a multilayer application which depends on how much disease is present. The physician would need to be the one to evaluate how much disease is present. The RUC accepted that there is compelling evidence that the technique involved in performing 96573 and 96574 has changed where the service can now necessitate physician work the same day as the procedure. It was also noted that previously, when the service was performed over two days, there would be some physician work that happened on the first day via a separately reported E/M service. The RUC noted that if physician work is included in 96573 and 96574, that same-day E/M services should be prohibited unless the service is for an unrelated diagnosis to the photodynamic therapy.

96567 ***Photodynamic therapy by external application of light to destroy premalignant ~~and/or malignant~~ lesions of the skin and adjacent mucosa with application and ~~(eg, lip) by~~ illumination/activation of photosensitive drug(s), per day ~~each phototherapy exposure session~~***

The RUC agreed that the coding structure for this family of services should cover situations both where the photodynamic therapy application was solely performed by the clinical labor staff and also if it was solely performed by a Physician. **To accomplish this, the RUC recommends that PE-only CPT code 96567 should be undeleted and remain zero physician work.** Also, the RUC agreed that the descriptor for 96567 should have an editorial change to "*Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s), per day.*"

96573 ***Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day***
The RUC reviewed the survey results from 88 dermatologists and agreed with the specialty on the following physician time components: 5 minutes of pre-service evaluation time, 10 minutes of intra-service time, and 5 minutes of immediate post-service time.

The RUC reviewed the survey 25the percentile work RVU of 0.92 and agreed that the survey respondents overvalued the work involved in performing this service. To find an appropriate work RVU crosswalk for CPT code 96573, the RUC compared the survey code to CPT code 99212 *Office or other outpatient visit for the evaluation and management of an established patient*, (work RVU=0.48, 10 minutes intra-service) and noted that both services involve an identical amount of intra-service time and a similar amount of physician work. Therefore, the RUC recommends a direct work RVU crosswalk from code 99212 to code 96573. For additional support, the RUC also referenced CPT code 99201 (work RVU=0.48, 10 minutes intra-service time), which also has identical intra-service time and involves a similar amount of physician work relative to 96573.

The RUC also agreed that the global for this code should be 000-day to avoid the potential for billing of same day E/M related to performing the photodynamic therapy service. Further, the RUC recommends that an NCCI edit of "1" should be applied to this code. In addition, the RUC agreed that a CPT parenthetical should be created to prohibit the performance of same-day E/M that is related to the photodynamic therapy and that it cannot be reported with 96567 or 96574. **The RUC recommends a work RVU of 0.48 for 96573, as well as a 000-day global period and a descriptor change so the service can only be provided by a physician or other qualified health care professional.** The RUC noted that their work RVU recommendation is contingent on CMS using the 000-day global and that CPT Editorial Panel implementing the recommended code changes.

96574 ***Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day***

The RUC reviewed the survey results from 69 dermatologists and agreed with the specialty on the following physician time components: 10 minutes of pre-service evaluation time, 16 minutes of intra-service time, and 10 minutes of immediate post-service time. The RUC noted that 96574 should include more post-service time relative to 96573, since in addition to the same post-service work as 96573, patients typically have additional bleeding following the curettage which often requires cautery.

The RUC reviewed the survey 25the percentile work RVU of 1.25 and agreed that the survey respondents overvalued the work involved in performing this service. To find an appropriate work RVU crosswalk for CPT code 96574, the RUC compared the survey code to CPT code 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU of 1.01, intra-service time of 15 minutes, total time of 36 minutes) and noted that both services have similar intra-service time, identical total time and involve a similar amount of physician work. Therefore, the RUC recommends a direct work RVU crosswalk from code 11042 to code 96574. For additional support, the RUC compared the survey code to CPT code 40490 *Biopsy of lip* (work RVU of 1.22, intra-service time of 15 minutes, total time of 34 minutes) and noted that the survey code has slightly more intra-service and total time, while also involving a comparable amount of physician work. The RUC also noted that the intra-service work intensity of 96574 should be somewhat higher than 96573 to account for the more intense physician work involved in performing the curettage.

The RUC also agreed that the global for this code should be 000-day to avoid the potential for billing of same day E/M related to performing the photodynamic therapy service. Further, the RUC recommends that an NCCI edit of "1" should be applied to this code. In addition, the RUC agreed that a CPT parenthetical should be created to prohibit the performance of same-day E/M that is related to the photodynamic therapy and that it cannot be reported with 96567 or 96573. **The RUC recommends a work RVU of 1.01 for 96574, as well as a 000-day global period and a descriptor change so the service can only be provided by a physician or other qualified health care professional.** The RUC noted that their work RVU recommendation is contingent on CMS using the 000-day global and that CPT Editorial Panel implementing the recommended code changes.

Practice Expense

The RUC reviewed the direct practice expense inputs as approved by the Practice Expense Subcommittee. As the Practice expense subcommittee convened prior to the RUC's decision to make several coding changes, the RUC made several modifications to the Practice Expense

Subcommittee's original recommendations. The RUC determined that the current practice expense inputs for undeleted code 96567 would be the same with the reduction of assist physician performing procedure to 0 minutes and including 10 minutes for the clinical staff to perform the procedure. Also the RUC determined that 2 minutes to check dressings & wound/home care instructions/coordinate office visits/prescriptions should be added to CPT 96567. In addition, the intraservice component of the service period to assist physician in performing procedure will be removed from CPT code 96573 and 96574. The RUC approved the direct practice expense inputs approved by the Practice Expense Subcommittee, though with the above modifications.

Global Period
The RUC also agreed that 96573 and 96574 should have the 000-day global period to avoid the potential for billing of related same day E/M related to performing the photodynamic therapy service.

Psychological and Neuropsychological Testing (Tab 18)
Jennifer Aloff, MD (AAFP); Donna Sweet, MD; Mary Newman, MD (CAP); Jeremy Musher, MD (APA); John Agens, MD (AGS); Kai-ping Wang, MD (AACAP); Jurgen Unitzer, MD, MPH (APA); Virna Little, PsyD, LCSW-r (APA)

In the July 2015 Proposed Rule and November 2015 Final Rule, CMS identified high expenditure services for review, include codes related to psychological and neuropsychological testing. In January 2016, the specialty societies requested that the entire family of psychological and neuropsychological testing codes be referred to the CPT Editorial Panel to be revised. The testing practice has been significantly altered by the growth and availability of technology, including computerized testing.The current codes do not reflect the multiple standards of practice and therefore result in confusion about how to report the codes. The RUC recommended that the entire psychological and neuropsychological testing codes be referred to the CPT Editorial Panel for revision. CMS also requested that CPT code 96125 and 96127 be added to this family of services for revision/review. In September 2016, the CPT Editorial Panel created seven codes to differentiate technician administration of psychological testing and neuropsychological testing from physician/ psychologist administration and assessment of testing; and deleted codes 96101-96103, 96111, 96118, 96119, 96120.

Organizations representing psychiatry, psychology, neurology, pediatrics and speech pathologists conducted a survey for the January 2017 RUC and HCPAC Review Board meetings. During this effort, it became apparent that further CPT revisions are required. Survey respondents were unable to articulate the work at the 60 or 30 minute coding increments and there is significant concern regarding the duplication of pre and post work as several units of service would be reported. Therefore, the organizations submitted a letter to the CPT Editorial Panel and the RUC to rescind the coding changes summarized below for *CPT 2018*. The organizations will submit a new coding proposal for consideration at the June 2017 CPT Editorial Panel meeting for *CPT 2019*. **The RUC supports referral to CPT.**

INR Monitoring (Tab 19)
Richard Wright, MD (ACC); Thad Waites, MD (ACC)

In October 2015, AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013 and these services were identified. In January 2016, the RAW recommended to survey G0250 along with G0248 and G0249 for April 2016. In April 2016, the specialty society indicated that they intend to develop Category I codes to describe home INR monitoring services for the September 2016 CPT meeting with review at the January 2017 RUC meeting. The RUC recommends that codes G0248, G0249

and G0250 be referred to CPT to create Category I codes to describe these services. In September 2016, the Editorial Panel deleted 99363 and 99364 and created two new codes.

93792 ***Patient/caregiver training for initiation of home INR monitoring under the direction of a physician or other qualified health care professional, including face-to-face, use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results***
CPT code 93792 is a practice expense only service performed by an RN, independent of a physician. The Practice Expense (PE) Subcommittee discussed that the intra-service portion of the service period recommended by the specialty society of 50 minutes and found that there was no clinical explanation for the established time, rather it was crosswalked from code G0248. Code G0248 was never reviewed by the PE Subcommittee and it is unclear how the time of 50 minutes in the G code was determined. The PE Subcommittee agreed with the specialty that an RN performs the service, but reduced the time of 50 minutes to 40 minutes. The Practice Expense (PE) Subcommittee made this reduction based on their own clinical expertise and recommends that survey data be obtained to better understand the time required. The Subcommittee also discussed that although an RN may perform the pre- and post-service tasks related to this service the training of an RN is not required. The PE Subcommittee determined that it is appropriate to change all clinical staff time apart from the intra-service portion of the service period to clinical staff type RN/LPN/MTA (L037D). **The PE Subcommittee recommends that this service be surveyed for practice expense the next time it is under review because it is performed by clinical staff independently.**

93793 ***Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab International Normalized Ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s) when performed***
The RUC reviewed the survey results from 57 cardiologists and agreed with the societies on the following physician time components: a pre-service time of 3 minutes, an intra-service time of 4 minutes and a post-service time of 2 minutes.

The specialty society explained that the vignette they selected for their survey pertained to a patient with a mechanical valve instead of a patient with arrhythmia as is what was the most common ICD-9 code grouping per the CY 2014 Medicare claims data available in the RUC database. In 2010, the first of the warfarin replacement anticoagulation medications were released; there are now four of these new novel direct-acting anticoagulants. In 2015, for the first time, the majority of patients placed on anticoagulant therapy were placed on one of these new agents. The expert panel projects that the usage of warfarin will decline. However, none of the new agents are recommended or indicated for mechanical valves, so those patients will remain on warfarin indefinitely for as long as they live. Mechanical valves are put in less frequently these days because of the durability of bovine pericardial valves. Hence, looking forward, as the mechanical valve patients eventually die, it is anticipated that warfarin will be used less and less. Currently, the CPT codes for management of INR (99363-99364) are designated as bundled services under Medicare, so the utilization of 93793 will go up in Medicare utilization for the first year once the work is reported using this new code.

The RUC reviewed the survey 25th percentile work RVU of 0.18 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.18, the RUC compared the survey code to MPC code 71010 *Radiologic examination, chest; single view, frontal* (work RVU of 0.18, intra-service time of 3 minutes, total time of 5 minutes) and noted that the survey code involves more intra-service and total time, supporting the proposed value for the survey code. To further support an RVU of 0.18, the RUC also compared the survey code to

CPT code 77080 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)* (work RVU of 0.20, intra-service time of 5 minutes, total time of 9 minutes) and noted that both services have similar intra-service time and identical total time. **The RUC recommends a work RVU of 0.18 for CPT code 93793.**

Practice Expense

CPT code 93792 is a practice expense only service performed by an RN, independent of a physician. The Practice Expense (PE) Subcommittee discussed that the intra-service portion of the service period recommended by the specialty society of 50 minutes and found that there was no clinical explanation for the time, rather it was crosswalked from the G code G0248. G code G0248 was never reviewed by the PE Subcommittee and it is unclear how the time of 50 minutes in the G code was determined. The PE Subcommittee agreed with the specialty that an RN performs the service, but reduced the time of 50 minutes to 40 minutes. The Practice Expense (PE) Subcommittee made this reduction based on their own clinical expertise and recommends that survey data be obtained to better understand the time required. The Subcommittee also discussed that although an RN may perform the pre- and post-service tasks related to this service the training of an RN is not required. The PE Subcommittee determined that it is appropriate to change all clinical staff time apart from the intra-service portion of the service period to clinical staff type RN/LPN/MTA (L037D). **The PE Subcommittee recommends that this service be surveyed for practice expense the next time it is under review because it is performed by clinical staff independently.**

Recommendation to Delete G codes G0248, G0249 and G0250

With the creation of new CPT codes 93792 and 93793, the RUC recommends for CMS to delete G codes 90248, 90249 and 90250.

Psychiatric Collaborative Care Management Services (Tab 20)

Jennifer Aloff, MD (AAFP); Donna Sweet, MD (ACP); Mary Newman, MD (ACP); Jeremy Musher, MD (APA); John Agens, MD (AGS); Kai-ping Wang, MD (AACAP); Jurgen Unitzer, MD, MPH (APA); Virna Little,PsyD, LCSW (APA)

In February 2016, the CPT Editorial Panel created three new codes to describe a model for providing psychiatric care in the primary care setting. This code set is one of several in response to a request from CMS to facilitate appropriate valuation of the services furnished under the Collaborative Care Model (CoCM). This CoCM is used to treat patients with common psychiatric conditions in the primary care setting through the provision of a defined set of services which operationalize the following core concepts: 1) Patient-Centered Team Care/Collaborative Care; 2) Population-Based Care; 3) Measurement-Based Treatment to Target; and 4) Evidence-Based Care.

In April 2016, the RUC reviewed the new code set for Psychiatric Collaborative Care Management, which captures a primary care physician working with a behavioral health manager and consulting psychiatrist to manage a patient's psychiatric care. The specialty societies requested that this issue be deferred until the January 2017 RUC meeting. The RUC noted that an Ad Hoc Workgroup has been created to provide feedback and guidance to the specialties involved to appropriately survey this code set. The Workgroup and the Research Subcommittee reviewed the unique survey plan and survey tool before it was launched. The RUC also recommended inclusion of a proposed G code, 99484, to be included in the survey for this issue as CMS finalized it in the Final Rule for 2017.

Specialty societies representing family medicine, internal medicine, geriatric medicine and psychiatry all participated in a survey in November/December 2016. Although the organizations received 80+ combined surveys, the number of primary care physicians responding is considered too low to be representative. The specialty societies concluded

that respondents estimated the total time spent by all physicians/behavioral health care managers during the course of the month, rather than their own individual time for which the specialties intended to sum. The RUC agreed that the time in this survey was not reliable. The RUC concurred with the specialties that the estimated work values followed the same pattern as the time estimates and were also not reliable. The RUC recommends that the following CMS times and work values be retained until sufficient experience is obtained to resurvey. When the services are reviewed again in two years, the RUC's Research Subcommittee will work with the specialties to design a survey instrument to better obtain physician time and work estimates.

●99492 *Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional* (**work RVU = 1.70, intra-time only = 40 minutes)**
●99493 *Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional* **(work RVU = 1.53, intra-time only = 36 minutes)**

●✚99494 *Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)* **(work RVU = 0.82, intra-time only = 18 minutes)**

●99484 *Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month* **(work RVU= 0.61, intra-time only = 15 minutes)**

Practice Expense
The PE Subcommittee reviewed the practice expense inputs which are similar to the CMS HCPCS codes outlined in the final rule for 2017. The Subcommittee agreed with the specialty societies that additional minimal supplies and equipment should be added into the direct practice expense inputs for 2018. The Subcommittee reduced the supply item, *tissue (Kleenex)* (SK114) from 1 to 0.05 to maintain consistency with other services utilizing this supply item. The Subcommittee notes that equipment time for the *One Couch and Two Chairs* (EF042) reflects usage during 45% of the time needed for care management activities. The RUC reviewed and approved the practice expense inputs as approved with modifications by the PE Subcommittee.

New Technology
These codes will be added to the new technology list so that they will be flagged for review in two years.

X. CMS Request/Relativity Assessment Identified Codes

CT Soft Tissue Neck (Tab 21)
Kurt A. Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Gregory N. Nicola, MD (ASNR)

In the Final Rule for 2016, CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 70491 was identified on the CMS high expenditure screen of potentially misvalued codes. CPT codes 70490 and 70492 were added as part of the family of services for CT of the neck.

Compelling Evidence
The specialty societies presented compelling evidence for CPT code 70492 *Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further section* that the original valuation was based on flawed methodology and there has been a change in technique and the patient population. The specialty societies stated that a flawed methodology was used in the previous valuation for this service as the code has a CMS/Other designation. As the RUC has noted previously during review of other services, codes with the CMS/Other designation were never surveyed by the RUC or any other stakeholder; the physician time and work were assigned by CMS in rulemaking over 20 years ago using an unknown methodology. Thus, CPT code 70492 does not have RUC validated survey times, or rationale available to validate the currently assigned work RVU.

Two different factors have worked concomitantly regarding a change in the typical patient for CPT code 70492 resulting in an overall increase in patient complexity. Firstly, the increased awareness of radiation dose and inefficient imaging has led to an increased scrutiny of indications for performing a single setting double CT such as CT neck with and without contrast. This is reflected in the Medicare claims data which shows a 24% reduction in the numbers of such CT scans being performed since 2009. This contraction in numbers has left a more complex patient population often having complex masses, prior surgeries, or infection. Additionally, in 2006, the 4D parathyroid CT scan, a multiphase CT scan, was first described for localization of parathyroid adenomas. It has become widely used, and is one of the most common protocols for this service. The former most common use for CPT code 70492 was to characterize a palpable mass simply by performing CT neck without contrast followed by contrast to determine whether the lesion was cystic or solid. CT parathyroid imaging requires a pre-contrast CT of the neck followed by CT neck with contrast performed in at least 2 different phases (often late arterial and delayed venous), essentially increasing the imaging volume by 33%. Surgeons have increasingly ordered this exam to assist in preoperative planning. Therefore, the patient population for CPT code 70492 has dramatically changed over the past decade following the development of this new technique. Interrogation of the acquired images for parathyroid adenoma also requires more skill than evaluating a palpable mass as the location of the adenoma is unknown.

The RUC accepted that there is compelling evidence that both patient complexity and technique have changed and, therefore, the amount of physician work involved in performing CPT code 70492 has increased. Further, that a flawed methodology was utilized when 70492 was originally valued.

70490 ***Computed tomography, soft tissue neck; without contrast material***
The RUC reviewed the survey results from 52 radiologists and neuroradiologists and determined that it was appropriate to maintain the current work RVU of 1.28, which is supported by the survey and is less than the 25th percentile of 1.30. The RUC recommends 5 minutes pre-service

time, 15 minutes intra-service time, and 5 minutes post-service time. The specialty societies clarified that the description of pre-service work correctly includes a determination of the appropriate CT protocol for the examination and that this protocol is performed by the physician.

The RUC compared the surveyed code to the top key reference service CPT code 70540 *Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)* (work RVU = 1.35, intra-service time of 19 minutes) and determined that CPT code 70540 requires more physician work, intra-service time and is slightly more intense and complex than the surveyed code. The surveyed code CT of the neck has a higher spatial resolution and thinner slices compared to MR of the neck. However, the top key reference code 70540, MRI has higher contrast resolution and requires more skill to interpret, therefore making it more intense. For additional support the RUC compared the surveyed code to the multi-specialty point of comparison CPT code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27, intra-service time of 15 minutes) and noted that both services have similar physician work and identical intra-service times and should be valued similarly. The RUC concluded that the key reference code and comparable MPC code support maintaining the current value for the surveyed code. **The RUC recommends a work RVU of 1.28 for CPT code 70490.**

70491 ***Computed tomography, soft tissue neck; with contrast material(s)***
The RUC reviewed the survey results from 52 radiologists and neuroradiologists and determined that it was appropriate to maintain the current work RVU of 1.38, which is supported by the survey and is below the 25th percentile of 1.46. The RUC recommends 5 minutes pre-service time, 17 minutes intra-service time, and 5 minutes post-service time.

The RUC compared the surveyed code to the top key reference service CPT code 70542 *Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)* (work RVU = 1.62, intra-service time of 20 minutes) and determined that the surveyed code requires slightly less physician time, less physician work and was indicated by the survey respondents as less intense and complex.. For additional support the RUC compared the surveyed code to the multi-specialty point of comparison CPT code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40, intra-service time of 18 minutes) and noted that both services have similar physician work and intra-service times and should be valued similarly. The RUC concluded that the key reference code and comparable MPC code support maintaining the current value for the surveyed code. **The RUC recommends a work RVU of 1.38 for CPT code 70491.**

70492 ***Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections***
The RUC reviewed the survey results from 52 radiologists and neuroradiologists and recommends the survey 25th percentile work RVU of 1.62. The RUC recommends 5 minutes pre-service time, 20 minutes intra-service time, and 5 minutes post-service time.

The RUC compared the surveyed code to the top key reference service CPT code 70543 *Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU = 2.15, intra-service time of 25 minutes). The RUC noted that the key reference service involves a lengthier intra-service time and is more intense and complex, therefore appropriately valued higher than the surveyed code. The slightly lower intensity and complexity for 70492 is supported by the survey respondents reporting slightly less technical skill for 70492 compared to 70543, but reporting otherwise similar intensity and complexity measures. The RUC also reviewed the multi-specialty point of comparison CPT code 74176 *Computed tomography, abdomen and pelvis; without contrast*

material (work RVU= 1.74, intra-service time of 22 minutes) and agreed that this comparison code supports a work RVU of 1.62 for the surveyed code. The recommendation is compared to the MPC code which demonstrates 2 minutes more of intra-service time and similar intensity and complexity to perform. Finally, for additional support, the RUC compared the surveyed code to CPT code 78072 *Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization* (work RVU = 1.60, intra-service time of 20 minutes), which requires similar physician work and time and thus valued the similarly.

As stated in the aforementioned rationale for compelling evidence, the RUC examined the survey 25th percentile work RVU of 1.62 and agreed that this value appropriately accounts for the physician work required to perform CPT code 70492. The RUC confirmed that the relativity for these three CT of the neck codes and across the larger family of CT codes is appropriate. **The RUC recommends a work RVU of 1.62 for CPT code 70492.**

Practice Expense
The RUC recommends the direct practice expense inputs as approved by the Practice Expense Subcommittee.

Ultrasound of Extremity (Tab 22)
PE Only – AAOS, ACR, ACRh, APMA

In February 2010, the CPT Editorial Panel created CPT codes 76881 *Ultrasound, extremity, nonvascular, real-time with image documentation; complete* and 76882 *Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific*. In April 2010, the RUC recommended a CPT Assistant article be written to ensure the proper reporting of these two services. It was noted by the RUC that these services should not typically be reported more than once per day. This service was flagged as New Technology/New Services and reviewed by the Relativity Assessment Workgroup (RAW) in January 2015. The Workgroup recommended that the specialty societies develop a CPT Assistant article to define the proper coding of extremity ultrasound, particularly as it applies to the elements necessary to report a complete study and that the Workgroup should review in October 2016 after two years of additional Medicare utilization data are available. This coding clarification was published in the September 2016 CPT Assistant.

In October 2016, the specialty society noted and the Workgroup agreed that there are two different dominant specialties providing the complete and the limited ultrasound of extremity services, causing variation in the typical practice expense inputs for each code. The RUC recommended to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs for January 2017; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019) at the Relativity Assessment Workgroup.

At the 2017 January RUC meeting the Practice Expense Subcommittee reviewed the direct practice inputs for CPT codes 76881 and 76882 and reduced the time for the *Technologist QC's images in PACS, checking for all images, reformats, and dose page* and *Review examination with interpreting MD* clinical activity input from 2 to 0 for 76881 only. Additionally, the supply input *pillow case*; SB037 was reduced from 1 to 0 for both services.

Following the meeting the specialty societies submitted a letter to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound.

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

New Technology
These services will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Cardiac Electrophysiology Device Monitoring Services (Tab 23)
Richard Wright, MD (ACC); Mark Schoenfeld, MD (HRS); Thad Waites, MD (ACC); David Slotwiner, MD (HRS)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. The specialty societies surveyed 93278-93292 at the October 2016 meeting. The specialty societies indicated that the survey respondents may have been unclear and responded per transmission instead of per 30-90 days for all transmissions. The RUC requested that the remote cardiac device monitoring codes 93293-93298 be resurveyed for January 2017 with specific direction that the service includes all transmissions for 30 or 90 days.

The specialty societies surveyed these remote cardiac monitoring services twice and the intra-service times were similar with each survey. The specialties noted and the RUC confirmed that the current intra-service times for these services were not survey times but were extrapolated from other codes in the family and should not be used to compare the time required to perform these services. Comparing the incorrect existing times demonstrate an artificial decrease in time.

93293 ***Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days***
The RUC reviewed the survey responses from 55 cardiologists and determined that the survey 25th percentile work RVU of 0.31 appropriately accounts for the work required to perform this service. The RUC recommends 3 minutes pre-service, 5 minutes intra-service and 5 minutes immediate post-service time. The RUC had previously derived at an appropriate work RVU and time by taking the frequency of reporting this service multiplied by the work RVU for 93010, therefore the previous work and time should not be used as a comparison.

The RUC compared the surveyed code to the top key reference code 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU = 0.52 and 15 minutes intra-service time) and agreed with the survey respondents that the surveyed code is slightly more intense and complex to perform, however code 93224 requires 10 more minutes intra-service time and thus is appropriately valued higher. The RUC also compared the surveyed code to the second top key reference service 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU = 0.30 and 5 minutes intra-service time) and noted that these services require similar intensity and complexity, physician time and work to perform and are valued similarly. For additional support the RUC referenced MPC codes 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU = 0.32 and 5 minutes intra-service time) and 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc*

perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent) (work RVU = 0.30 and 7 minutes intra-service time), which provide a good comparison relative to services in the Medicare physician payment schedule. **The RUC recommends a work RVU of 0.31 for CPT code 93293.**

93294 ***Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional***

The RUC reviewed the survey responses from 64 cardiologists and determined that the survey 25th percentile work RVU of 0.60, below the current value, appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes pre-service, 10 minutes intra-service and 5 minutes immediate post-service time. The RUC had previously derived at an appropriate work RVU and time by taking the frequency of reporting this service multiplied by the work RVU for 93288, therefore the previous work and time should not be used as a comparison.

The RUC compared the surveyed code to the top key reference code 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU = 0.52 and 15 minutes intra-service time) and agreed with the survey respondents that the surveyed code is slightly more intense and complex to perform, thus is appropriately valued higher. For additional support the RUC referenced similar MPC codes 76815 *Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses* (work RVU = 0.65 and 5.5 minutes intra-service time) and 69210 *Removal impacted cerumen requiring instrumentation, unilateral* (work RVU = 0.61 and10 minutes intra-service time), which provide a good comparison relative to services in the Medicare physician payment schedule. **The RUC recommends a work RVU of 0.60 for CPT code 93294.**

93295 ***Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional***

The RUC reviewed the survey responses from 64 cardiologists and determined that the survey 25th percentile work RVU of 0.69 and median work RVU of 0.95 did not appropriately account for the work required to perform this service. Based on the RUC pre-facilitation comments, the specialty society and the RUC recommends a direct crosswalk to CPT code 76770 *Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete* (work RVU = 0.74 and 10 minutes intra-service time). The RUC recommends 5 minutes pre-service, 10 minutes intra-service and 5 minutes immediate post-service time. The RUC noted that although 93294 and 93295 require the same physician time, there is an increased intensity and amount of information considered when reading ICD interrogations (93295) versus pacemaker interrogations (93294) and thus are valued differently. The RUC noted that the current intra-time of 22.5 minutes is an extrapolated calculation from that of the times of 93289, additionally the April 2008 survey times are incorrect in the RUC database. The April 2008 survey times were 5 minutes pre/15 minutes intra/5 minutes immediate post-service time and the 25th percentile work RVU of 0.78. The RUC confirmed that the previous times and work RVU calculations could not be used as comparison as they reflect an artificial decrease in physician time.

The RUC compared the surveyed code to the top key reference code 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or*

other qualified health care professional (work RVU = 0.52 and 15 minutes intra-service time) and agreed with the survey respondents that the surveyed code is more intense and complex to perform, thus is appropriately valued higher. For additional support the RUC referenced similar MPC codes 99213 *Office or other outpatient visit for the evaluation and management of an established patient,* (work RVU = 0.97 and 15 minutes intra-service time) and 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86 and 8 minutes intra-service time), which provide a good comparison relative to services in the Medicare physician payment schedule. **The RUC recommends a work RVU of 0.74 for CPT code 93295.**

93297 ***Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional***
The RUC reviewed the survey responses from 56 cardiologists and determined that the current work RVU of 0.52, below the survey 25th percentile, appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes pre-service, 6 minutes intra-service and 5 minutes immediate post-service time. The RUC noted that the current intra-time of 24 minutes is an extrapolated calculation from that of the times of 93290, additionally the April 2008 survey times are incorrect in the RUC database. The April 2008 survey times were 5 minutes pre/12 minutes intra/8 minutes immediate post-service time. The RUC confirmed that the previous times and work RVU calculations could not be used as comparison as they reflect an artificial decrease in physician time.

The RUC compared the surveyed code to the top key reference code 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU = 0.52 and 15 minutes intra-service time) and agreed with the survey respondents that the surveyed code is more intense and complex to perform and requires less physician time. For additional support the RUC referenced similar MPC codes 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU = 0.56 and 10 minutes intra-service time) and 76857 *Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)* (work RVU = 0.50 and 7 minutes intra-service time), which provide a good comparison relative to services in the Medicare physician payment schedule. For additional support the RUC reference 92136 *Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation* (work RVU = 0.54 and 5 minutes intra-service time). **The RUC recommends a work RVU of 0.52 for CPT code 93297.**

93298 ***Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional***
The RUC reviewed the survey responses from 64 cardiologists and determined that the current work RVU of 0.52, which is also the survey 25th percentile, appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes pre-service, 7 minutes intra-service and 5 minutes immediate post-service time. The RUC noted that the current intra-time of 24 minutes is an extrapolated calculation from that of the times of 93290, additionally the April 2008 survey times are incorrect in the RUC database. The April 2008 survey times were 5 minutes pre/10 minutes intra/5 minutes immediate post-service time. The RUC confirmed that the previous times and work RVU calculations could not be used as comparison as they reflect an artificial decrease in physician time.

The RUC compared the surveyed code to the top key reference code 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU = 0.52 and 15 minutes intra-service time) and agreed with the survey respondents that the surveyed code is more intense and complex to perform and requires less physician time. For additional support the RUC referenced similar MPC codes 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU = 0.56 and 10 minutes intra-service time) and 76857 *Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)* (work RVU = 0.50 and 7 minutes intra-service time), which provide a good comparison relative to services in the Medicare physician payment schedule. For additional support the RUC reference 92136 *Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation* (work RVU = 0.54 and 5 minutes intra-service time). **The RUC recommends a work RVU of 0.52 for CPT code 93298.**

Affirmation of RUC Recommendations
The RUC affirmed the recent RUC recommendations for CPT codes 93279-93292, previously submitted for the same *CPT 2018* cycle. The relativity within the family remains correct.

Practice Expense
The RUC reviewed the direct practice expense inputs for this entire family at the October 2016 RUC meeting and are attached to this recommendation.

Work Neutrality
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Intracardiac 3D Mapping Add-On (Tab 24)
Richard Wright, MD (ACC); Mark Schoenfeld, MD (HRS); Thad Waites, MD (ACC); David Slotwiner, MD (HRS)

In the NPRM for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. In the comment letter the RUC noted that it was scheduled to review the utilization and collect data under new bundled codes in October 2016. However, in the Final Rule for 2016 CMS indicated that the work and practice expense for this service should be reviewed.

93613 ***Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 47 cardiologists and determined that the survey 25th percentile work RVU of 5.23 appropriately accounts for the work required to perform this service. The RUC recommends 90 minutes intra-service time. The RUC determined that the decrease in the recommended work RVU appropriately corresponds to the decrease in intra-service work. The RUC edited the description of work to delete "remove the catheter and obtaining hemostasis" as this is associated with the primary procedure. The RUC compared the surveyed code to the top key reference service 93609 *Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure*) (PC work RVU = 4.99 and 90 minutes intra-service time) and determined that this service was slightly more intense and complex on all measures examined. The RUC also compared the surveyed code to the

second top key reference code 93655 *Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)* (work RVU = 7.50 and 90 minutes intra-service time) and determined that code 93655 is more intense than the surveyed code because it entails the initiation and prolonged observation (to allow for mapping, the surveyed code) of arrhythmias that are potentially dangerous and/or hemodynamically unstable with increased risk to the patient and thereafter requires ablation which in and of itself carries precision and risk- it requires greater intensity to perform the complex initiation of arrhythmias and to manage such patients while these arrhythmias are being mapped in order to allow for the subsequent ablation. In addition, any patient who has more than one arrhythmia focus becomes exponentially complex. The diagnostic maneuvers, mapping and ablation skills needed to successfully treat a second focus are significant. Not all arrhythmia foci are created equally. Patients who have more than one focus tend to have significant scar tissue. Mapping the circuit of the arrhythmia is particularly challenging because distinguishing between partly viable tissue and complete scare requires a very dense map (meaning many data points must be acquired and correctly interpreted and annotated on the map).

For additional support the RUC referenced MPC code 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU = 4.88 and 45 minutes intra-service time) and noted that the MPC code is much more intense and requires half the intra-service time. **The RUC recommends a work RVU of 5.23 for CPT code 93613.**

Practice Expense
There are no direct practice expense inputs for this service.

Work Neutrality
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

IV Hydration (Tab 25)
Elizabeth Blanchard, MD (ASCO); David Regan (ASH)

In the NPRM for 2016, CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management (E/M) services and services reviewed since CY 2010. CPT code 96360 was part of that list to be surveyed and CPT code 96361 was added as part of the family. This two code IV Hydration family was previously surveyed and reviewed by the RUC as part a 20-code project conducted by a multispecialty coalition at the October 2004 RUC meeting.

The RUC discussion recalled that, as part of the October 2004 undertaking, the twenty codes were considered in context and a hierarchy was created through the work RVUs that started with the presumption that the lowest service was hydration and that it should not be valued lower than CPT code 99211. CMS provided further history and emphasized that there are certain E/M expectations with the hydration codes. These services are not just supervision codes in the sense that CMS is expecting that, since there is some evaluation and management value included, physicians will assess the patient when necessary and make course corrections. Further, there was a statutory provision that talked about the fact that certain evaluation services would be included and that has been reflected in the Level I (99211) office visit that was included in the work for these codes.

96360 ***Intravenous infusion, hydration; initial, 31 minutes to 1 hour***
The RUC reviewed the survey results from 52 medical oncologists and hematologists and determined that it was appropriate to maintain the current work RVU of 0.17, which is supported by the survey and is less than the 25th percentile of 0.21. The RUC recommends 2 minutes pre-service time, 3 minutes intra-service time, and 2 minutes post-service time. The RUC compared the surveyed code to the top key reference service 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21, intra-service time of 5 minutes). The intensity/complexity measures of the surveyed code were similar to the ratings assigned to the reference code. Given the similarity in times and the minimal difference in the intensity/complexity measures, the survey data supports maintenance of the current value of 0.17. The RUC agreed with the consensus of the specialty societies that the physician work of this service and time involved has not fundamentally changed since 2004 which would not justify a substantial increase from the current level and therefore recommends the current times and work RVU be maintained.

To provide further support, the RUC compared the surveyed code to both the multi-specialty point of comparison CPT code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16, intra-service time of 3 minutes) and CPT code 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services* (work RVU = 0.18, intra-service time of 5 minutes). The RUC considered the time and intensity associated with the surveyed code to be comparable to that of these similar services and determined the current RVW places this code in appropriate rank order to those services in terms of physician work.

The RUC recommends maintaining the current work RVU of 0.17, which is consistent with the conclusion that there have not been fundamental changes to the physician work and continues to align with CPT code 99211 per the 2004 rationale. **The RUC recommends a work RVU of 0.17 for CPT code 96360.**

96361 ***Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 50 medical oncologists and hematologists and determined that it was appropriate to maintain the current work RVU of 0.09, which is supported by the survey and is less than the 25th percentile of 0.19. The RUC recommends 3 minutes of intra-service time for this add-on (ZZZ) code. The survey median intra-service time was 10 minutes and the 25th percentile intra time was 5 minutes; the current intra-service time assigned is 3 minutes. The RUC agreed with the consensus of the specialty societies that the physician work of this service has not fundamentally changed since 2004 and recommends that the current time and work RVU be maintained as they are similar with the 25th percentile from the recent survey. The RUC compared the surveyed code to the top key reference service 96367 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)* (work RVU = 0.19, intra-service time of 5 minutes). The intensity/complexity measures for the surveyed code were rated similar, however since the service has not changed, the RUC would agree with the specialty societies and not recommend an increase in value.

For additional support, the RUC compared the surveyed code to both the multi-specialty point of comparison CPT code 95165 *Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)* (work RVU = 0.06, intra-service time of 3 minutes) and CPT code 96153 *Health and*

behavior intervention, each 15 minutes, face-to-face; group (2 or more patients) (work RVU = 0.10, intra-service time of 3 minutes). The surveyed code is the second hour of hydration, and there would be a need for some nurse/physician interaction. The specialties reaffirmed that the work related to this code was about half of the work associated with 96360 (as similarly noted by the RUC for codes 90760 and 90761, in the RUC rationale from the October 2004 survey).

The RUC recommends maintaining the current RVW of 0.09, which is consistent with the conclusion that there have not been fundamental changes to the physician work and there is no compelling evidence for an increase in the work value. **The RUC recommends a work RVU of 0.09 for CPT code 96361.**

Practice Expense
Modifications were made to the direct practice expense inputs including the elimination of all duplicative clinical staff time with the E/M. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Application of On-body Injector with Subcutaneous Injection (Tab 26)
Dr. Jennifer Aloff (AAFP); Dr. David Regan, (ASCO); Dr. Elizabeth Blanchard (ASH)
Doctor Silver recused himself from voting on Tab 26.

At the October 2015 panel meeting the CPT Editorial Panel created a new code, CPT code 96377 *Application of on-body injector (includes cannula insertion) for timed subcutaneous injection*, for the administration of neupogen following chemotherapy. The manufacturer of the on-body injector that administers the medication submitted the code proposal and presented to the Panel. Although the specialty society did not develop the code proposal they are strongly supportive of the application. The drug cannot be administered until 24 hours after chemotherapy and patients are often required to return to the office for administration. This is a considerable burden for patients who live in rural areas and may have to travel hundreds of miles for such treatment and the specialty supports the service as it is an important method of administration for this drug.

As the specialty societies prepared to survey CPT code 96377, it was determined that a targeted sample was necessary to appropriately survey this code. This type of survey needs to be approved by the Research Subcommittee; however, the deadline for approval had already passed. In a letter to the RUC the specialty societies requested that the survey be delayed to the April 2016 RUC meeting. Subsequent to that letter being submitted the specialty determined there are other injection/ IV push codes part of the same family as the new codes (96372, 96374, 96375) and that the codes should be surveyed together. The other injection services in the family (96372, 96374, and 96375) are high volume and were been identified by the Relativity Assessment Workgroup for survey and review by the RUC at the October 2016 RUC meeting. It will be necessary to gain involvement from other specialty societies that perform injection services. The societies that perform these services will review potential changes to the overall family of injection/ IV push codes and provide revised introductory material for the CPT book. The specialty societies planned to survey the entire family of injection/IV push services for the October 2016 RUC meeting.

The RUC considered the recommendation of the specialty societies and agreed that the new service along with three other codes in the family, CPT codes 96372, 96374 and 96375 should be surveyed for the October 2016 RUC meeting. The RUC also agreed with the recommendation that the new service 96377 should be carrier priced for 2017. The RUC recommended survey of CPT codes 96372, 96374, 96375 and 96377 for review at the October 2016 RUC meeting and recommended to carrier price CPT code 96377 for 2017. The CPT Editorial Panel questioned whether physician work is involved in 96377 or if it is practice expense only. In June 2016, the

specialty societies indicated that they would not proceed with a coding change proposal and would survey for January 2017.

96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*

The RUC reviewed surveys from 110 physicians and determined that the current work RVU of 0.17 appropriately accounts for the work required to perform this service. The RUC recommends 2 minutes pre-service evaluation time, 3 minutes intra-service time and 2 minutes immediate post service time. Although the survey 25th percentile and median work values and time components were all higher, the specialty societies indicated that the work and time for this service has not fundamentally changed. The RUC noted that 96372 is typically performed with an Evaluation and Management service (52% of the time), and the pre-service time, post-service time and practice expense inputs do not include any duplication.

The RUC compared the surveyed code to the top two key reference services CPT code 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21 and 5 minutes intra-service time) and 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (work RVU = 0.28 and 7 minutes intra-service time) and noted that the respondents indicated that the surveyed code is less intense and complex on almost all measures examined. For additional support, the RUC referenced MPC codes 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16 and 3 minutes intra-service time) and 99211 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.18 and 7 minutes total time), which provide better references regarding the relativity for physician work and time across the payment schedule. **The RUC recommends a work RVU of 0.17 for CPT code 96372.**

96374 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug*

The RUC reviewed surveys from 80 physicians and determined that the current work RVU of 0.18 appropriately accounts for the work required to perform this service. The RUC recommends 2 minutes pre-service evaluation time, 5 minutes intra-service time and 2 minutes immediate post service time. Although the survey 25th percentile and median work values and time components were all higher, the specialty societies indicated that the work and time for this service has not fundamentally changed. The RUC compared the surveyed code to the top two key reference services CPT code 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21 and 5 minutes intra-service time) and 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (work RVU = 0.28 and 7 minutes intra-service time) and noted that the respondents indicated that the surveyed code is slightly more intense and complex on almost all measures examined. For additional support the RUC referenced MPC codes 51741 *Complex uroflowmetry (eg, calibrated electronic equipment)* (work RVU = 0.17 and 7 minutes total time) and 99211 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.18 and 7 minutes total time), which provide better references regarding the relativity for physician work and time across the payment schedule. **The RUC recommends a work RVU of 0.18 for CPT code 96374.**

96375 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)*

The RUC reviewed surveys from 77 physicians and determined that the current work RVU of 0.10 appropriately accounts for the work required to perform this service. The RUC recommends 4 minutes intra-service time. Although the survey 25th percentile and median work values and

time components were all higher, the specialty societies indicated that the work and time for this service has not fundamentally changed. The RUC compared the surveyed code to the top two key reference services CPT code 96417 *Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)* (work RVU = 0.21 and 6 minutes intra-service time) and 96367 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)* (work RVU = 0.19 and 5 minutes intra-service time) and noted that the respondents indicated that overall the surveyed code is slightly less intense and complex than 96417 and slightly more intense and complex than 96367. For additional support the RUC referenced MPC codes 95165 *Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)* (work RVU = 0.06 and 3 minutes intra-service) and 96153 *Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)* (work RVU = 0.10 and 3 minutes intra-service time), which provide better references regarding the relativity for physician work and time across the payment schedule. **The RUC recommends a work RVU of 0.10 for CPT code 96375.**

96377 *Application of on-body injector (includes cannula insertion) for timed subcutaneous injection*

The RUC reviewed surveys from 60 physicians and determined that a work RVU of 0.17, slightly below the survey 25th percentile, appropriately accounts for the work required to perform this service. The RUC recommends 2 minutes pre-service evaluation time, 5 minutes intra-service time and 2 minutes immediate post service time. The specialty society clarified that this service is typically reported on the same day as chemotherapy administration. A RUC member questioned how many injections and cycles are typical, the specialty societies indicated that the patient is injected once per cycle and there are typically 4-6 cycles.

The RUC compared the surveyed code to the top two key reference services CPT code 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21 and 5 minutes intra-service time) and 36410 *Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)* (work RVU = 0.18 and 5 minutes intra-service time) and noted that the respondents indicated that the surveyed code is overall less intense and complex. However, the specialty societies did not agree. The specialties societies indicated that the service provided in 96377 was more closely related to 96372 rather than 96374 when considering the intensity and complexity of the patient, risk of complications, and likelihood that that the physician would be asked to intervene. The specialty society recommends to maintaining relativity between the services. Therefore, the work RVUs for CPT code 96377 should be slightly less physician work than 96374 and more similar to 96372.

Using magnitude estimation, the specialty societies compared 96377 to similar services 51741 *Complex uroflowmetry (eg, calibrated electronic equipment)* (work RVU = 0.17 and 5 minutes intra-service time), 77086 *Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)* (work RVU = 0.17 and 5 minutes intra-service time), and 93050 *Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive* (work RVU = 0.17 and 5 minutes intra-service time), which provide better references regarding the relativity for physician work and time across the payment schedule. **The RUC recommends a work RVU of 0.17 for CPT code 96377.**

The RUC noted that CMS has assigned CPT code 96377 a status of "I", Invalid. **The RUC requests that CMS consider the RUC recommendation for immediate implementation and communicate the change in coverage to physicians.**

Practice Expense
The Practice Expense Subcommittee modified the direct practice expense inputs by eliminating any duplicative E/M services, minor adjustments to some supplies, adjusted equipment due to changes in clinical staff time. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Chemotherapy Administration (Tab 27)
Elizabeth Blanchard, MD (ASH); David Regan, MD (ASCO); Frederica Smith, MD (ACRh)

In the NPRM for 2016, CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. In June 2016, the specialty societies indicated that they would not proceed with a coding change proposal as originally intended and will survey for January 2017.

A RUC member questioned if the chemotherapy substance is divided into aliquots and given multiple injections. The specialty societies indicated that it is not typical and it is confirmed by CPT introductory language that the substance injection is reported once and would not be able to be reported multiple times even if it was divided. Based on the preliminary reviewer comments, a RUC member questioned if these services were reported together multiple times and the reported together Medicare claims data for the same patient/same physician/same day showed that the chemotherapy administration codes are performed a median of one time (same day, same provider for the same beneficiary).

96401 ***Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic***
The RUC reviewed surveys from 66 physicians and determined that the current work RVU of 0.21, which is also the survey 25th percentile, appropriately accounts for the work required to perform this service. The RUC recommends maintaining the current times of 4 minutes pre-service evaluation time, 3 minutes intra-service time and 2 minutes immediate post service time. The specialty societies indicated the physician work and time has not fundamentally changed since 2004, which would not justify a substantial increase in time from the current level. Therefore, recommend the current times be maintained as they are similar to the 25th percentile times from the recent survey.

The RUC compared the surveyed code to the top two key reference services CPT code 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (work RVU = 0.28 and 7 minutes intra-service time) and 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21 and 5 minutes intra-service time) and noted similar intensity and complexity for these services. Given the similarity in physician times and the minimal difference in the intensity/complexity measures, the RUC determined that the survey data supports maintenance of the current value of 0.21.

For additional support the RUC referenced MPC code 92567 *Tympanometry (impedance testing)* (work RVU = 0.20 and 4 minutes intra-service time) and 96417 *Office or other outpatient visit for the evaluation and management of an established patient Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)* (work RVU = 0.21 and 6 intra-service time), which demonstrate appropriate relativity for physician work and time across the payment schedule. **The RUC recommends a work RVU of 0.21 for CPT code 96401.**

96402 *Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic*

The RUC reviewed surveys from 118 physicians and determined that the current work RVU of 0.19, which is slightly below the survey 25th percentile, appropriately accounts for the work required to perform this service. The RUC recommends maintaining the current times of 4 minutes pre-service evaluation time, 3 minutes intra-service time and 2 minutes immediate post service time. The specialty societies indicated the physician work and time has not fundamentally changed since 2004, which would not justify a substantial increase in time from the current level. Therefore, recommend the current times be maintained as they are similar to the 25th percentile times from the recent survey. The RUC noted that this service is reported with an Evaluation and Management service 65% of the time and confirmed no duplication in the pre- and post-service time.

The RUC compared the surveyed code to the top two key reference services CPT code 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (work RVU = 0.28 and 7 minutes intra-service time) and 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21 and 5 minutes intra-service time) and noted similar intensity and complexity for these services. Given the similarity in physician times and the minimal difference in the intensity/complexity measures, the RUC determined that the survey data supports maintenance of the current value of 0.19.

For additional support the RUC referenced MPC code 92567 *Tympanometry (impedance testing)* (work RVU = 0.20 and 4 minutes intra-service time) and 96367 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)* (work RVU = 0.19 and 5 minutes intra-service time), which demonstrate appropriate relativity for physician work and time across the payment schedule. **The RUC recommends a work RVU of 0.19 for CPT code 96402.**

96409 *Chemotherapy administration; intravenous, push technique, single or initial substance/drug*

The RUC reviewed surveys from 59 physicians and determined that the current work RVU of 0.24, which is slightly below the survey 25th percentile, appropriately accounts for the work required to perform this service. The RUC recommends maintaining the current times of 4 minutes pre-service evaluation time, 5 minutes intra-service time and 2 minutes immediate post service time. The specialty societies indicated the physician work and time has not fundamentally changed since 2004, which would not justify a substantial increase in time from the current level. Therefore, recommend the current times be maintained as they are similar to the 25th percentile times from the recent survey.

The RUC compared the surveyed code to the top key reference service CPT code 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (work RVU = 0.28 and 7 minutes intra-service time) and noted similar intensity

and complexity for these services. Given the similarity in physician times and the minimal difference in the intensity/complexity measures, the RUC determined that the survey data supports maintenance of the current value of 0.24.

For additional support the RUC referenced MPC codes 71020 *Radiologic examination, chest, 2 views, frontal and lateral;* (work RVU = 0.22 and 3 minutes intra-service time) and 93922 *Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries…* (work RVU = 0.25 and 5 minutes intra-service time), which demonstrate appropriate relativity for physician work and time across the payment schedule. The RUC questioned why 96409 and 96411 require more physician work than 96401 and 96402. The specialty society indicated that when chemotherapy administration is given via intravenous push there is an increased risk of side effects and problems that can relate to it, such as chest pain and vasospasms from specific IV push drugs. **The RUC recommends a work RVU of 0.24 for CPT code 96409.**

96411 ***Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)***
The RUC reviewed surveys from 57 physicians and determined that the current work RVU of 0.20, which is slightly below the survey 25th percentile, appropriately accounts for the work required to perform this service. The RUC recommends maintaining the current time 3 minutes pre-service time and 4 minutes intra-service time. The specialty societies indicated the physician work and time has not fundamentally changed since 2004, which would not justify a substantial increase in time from the current level. Therefore, recommend the current times be maintained as they are similar to the 25th percentile times from the recent survey. The RUC noted that this service is reported with an Evaluation and Management (E/M) service 58% of the time and confirmed no duplication in the pre- and post-service time.

CMS questioned what the physician work involves, outside of supervision of clinical staff, and was concerned with any overlap with E/M services provided. The specialty societies indicated that E/M visits are separate and distinct from this service and focus on disease management, review imaging and inform patient of status of cancer. Whereas, this service is the supervision of the infusion and frequent assessment, addressing of medication reactions and interaction with clinical staff.

The RUC compared the surveyed code to the top two key reference services CPT code 96417 *Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)* (work RVU = 0.21 and 6 minutes intra-service time) and CPT code 96367 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)* (work RVU = 0.19 and 5 minutes intra-service time) and noted slightly higher intensity and complexity for the surveyed service. Given the similarity in physician times and the minimal difference in the intensity/complexity measures, the RUC determined that the survey data supports maintenance of the current value of 0.20.

For additional support the RUC referenced codes 77080 *Radiologic examination, chest, 2 views, frontal and lateral;* (work RVU = 0.20 and 5 minutes intra-service time) and 71100 *Radiologic examination, ribs, unilateral; 2 views* (work RVU = 0.22 and 4 minutes intra-service time), which demonstrate appropriate relativity for physician work and time across the payment schedule. The RUC questioned why 96409 and 96411 require more physician work than 96401 and 96402. The specialty society indicated that when chemotherapy administration is given via intravenous push there is an increased risk of side effects and problems that can relate to it, such as chest pain and

vasospasms from specific IV push drugs. **The RUC recommends a work RVU of 0.20 for CPT code 96411.**

Practice Expense
The Practice Expense Subcommittee made minor modifications to the clinical staff time, supplies and eliminated any overlap with duplicative services if reported with an Evaluation and Management service in accordance with the standards. CMS questioned if the time per clinical staff activity, such calculating the body surface area (BSA), calculating the dose, etc. is appropriate. The specialty society indicated that chemotherapy can be quite toxic and definitely requires careful calculations for each time the patient receives these services. The patient changes frequently, and their weight and height must be measured each time to insure accuracy. A 10% weight change could impact the appropriate dose. The RUC recommends the direct practice expense inputs as approved with modifications by the PE Subcommittee.

XI. Practice Expense Subcommittee (Tab 28)

Doctor Scott Manaker, Chair, provided a summary of the report of the Practice Expense (PE) Subcommittee:

- **Scope Systems and Endoscopes Workgroup**

The Scope Systems and Endoscopes Workgroup was formed at the October 2016 RUC meeting and met via conference call on November 2, 2016 to discuss the Centers for Medicare and Medicaid Services (CMS) request for standardization within the description of scope equipment and supplies. The CMS Final Rule was released after the conference call and CMS finalized the proposal, without offering to delay pending input from the Workgroup. CMS intention is to further standardize how the inputs used for endoscopes are reported by dividing them into specific categories of scopes, a single system used to operate the scopes and specifying what each of the necessary accessories are. No further action is required of the Workgroup at this time.

- **Standard Equipment Related to Non-Moderate Sedation Post-Procedure Monitoring**

The Standard Equipment Related to Non-Moderate Sedation Post-Procedure Monitoring Workgroup met via conference call on October 20, 2016, to discuss post-procedure monitoring that continues to be necessary even as moderate sedation is now a separately billable service. For a number of services an hour of recovery following moderate sedation is needed and then additional monitoring of the recovery is needed. The Workgroup agreed that continued use of the stretcher only is standard for this scenario. If the patient is being monitored for an extended period of time such as following vascular access the standard equipment in addition to the stretcher will be an IV infusion pump and ECG.

The Workgroup also discussed the issue of the proper allocation of oxygen for services done with moderate sedation. There are a very limited number of services with oxygen as a supply item and the Workgroup determined if it was included in the services for moderate sedation or for other purposes. If it was included for moderate sedation the Workgroup pulled it out.

The Workgroup recommends that prospectively when extended monitoring beyond one hour for a procedure with moderate sedation is necessary; a stretcher (EF018) should be allocated. When extended monitoring beyond the procedure time is necessary due to concerns regarding bleeding; an ECG, 3-channel (with SpO2, NIBP, temp, resp) (EQ011), IV infusion pump (EQ032) and a stretcher (EF018) should be allocated. Additionally all services that include oxygen and the rationale for its maintenance or deletion is included in the PE Subcommittee Report.

- **High Cost Medical Supplies and Equipment**

The Chair of the PE Subcommittee asked if it is helpful to the RUC for him to call out high priced supplies and equipment. Several members of the RUC expressed that it is helpful, even if there is nothing that can be done about the price it is important to be aware of the items and also be aware of how these items are pulling resources within a limited pool. AMA staff reminded members that the RUC has repeatedly called on CMS to separately identify and pay for high cost disposable supplies using distinct J codes, rather than bundle into the service described by CPT so that these expenses may be monitored closely and paid appropriately. For example, there are approximately 55 supply items over $500 and 33 supply items that CMS has priced in excess of $1,000.

The RUC approved the Practice Expense Subcommittee Report.

XII. HCPAC Review Board (Tab 29)

Doctor White provided a summary of the report of the HCPAC Review Board report. The RUC expressed appreciation to Jane White, PhD, RD for her service as she retires from the HCPAC.

- **HCPAC Elections**

The American Speech Language and Hearing Association Advisor, Dee Adams Nikjeh, PhD, CCP-SLP, was elected Co-Chair of the HCPAC Review Board and the American Podiatric Medical Association, Timothy Tillo, DPM, was elected alternate Co-Chair of the RUC HCPAC Review Board.

- **CPT 2018 Recommendations**

Cognitive Function Intervention (97127)
Renee Kinder, MA, CCC-SLP (ASHA); Neil Pliskin, PhD (APA)

CPT code 97532 *Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes* was identified in October 2013 through the High Volume Growth screen. At that time the RUC recommended to maintain the current value as the entire Physical Medicine and Rehabilitation (PM&R) code section is under revision. In October 2015, AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013. The RUC reviewed this list and recommended that the specialty societies submit an action plan for January 2016 explaining the high volume growth. In January 2016, the RAW indicated that this service is part of the CPT PM&R Workgroup under revision and the code was removed from screen. In April 2016 the Relativity Assessment Workgroup reviewed the action plan time line and recommended that the service be referred to CPT for revision to reflect current practice. At the September 2016 CPT Editorial Panel Meeting the panel deleted 97532 and created CPT code 97127 *Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks, direct (one-on-one) patient contact* to describe therapeutic interventions.

CPT code 97127 will replace former code 97532 (work RVU = 0.44), a service that was reported in increments of 15 minutes and typically reported with 4 units of service. The HCPAC reviewed the survey results from 160 speech-language pathologists and psychologists and agreed with the societies on the following time components: a pre-service time of 5 minutes, an intra-service time of 60 minutes and a post-service time of 10 minutes.

The Review Board reviewed the specialty societies recommended work RVU of 1.76, between the 25th and 50th percentile and disagreed with the specialty societies that it was an appropriate value for the work involved in this service. The Review Board then looked at the survey 25th percentile work RVU of 1.31 and determined that it undervalued the work involved in performing this service. The Review Board determined that a direct crosswalk to CPT code 92522 *Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)* (work RVU=1.50 and pre-service time of 5, intra-service time of 60 and post-service time of 20) as both of these service require similar time and work to complete. For additional support the HCPAC compared the surveyed service to the top key reference code 92507 *Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual* (work RVU=1.30, intra-service time of 50 minutes, total time of 60 minutes) and noted that the surveyed service has more intra-service time, is more intense to perform and is appropriately valued higher. **The HCPAC recommends a work value of 1.50 for CPT code 97127.**

Practice Expense
There is no clinical staff time related to this service. The only inputs are for supplies and equipment for the health care professional's use. 60 minutes of equipment time for the table, instrument, mobile (EF027) and notebook (Dell Latitude D600) (ED038) reflect the work intra-service time. The Review Board approved the practice expense inputs as reviewed and modified by the PE Subcommittee.

Psychological and Neuropsychological Testing (RUC - 96110, 96116, 96131-2, 96134, 96136, 96127; HCPAC – 96105, 96125, 96130, 96133, 96135)
Leisha Eiten, AuD, CCC-A (ASHA); Randy Phelps, PhD (APA)

In the July 2015 Proposed Rule and November 2015 Final Rule, CMS identified high expenditure services for review, including codes related to psychological and neuropsychological testing. In January 2016, the specialty societies requested that the entire family of psychological and neuropsychological testing codes be referred to the CPT Editorial Panel to be revised. The testing practice has been significantly altered by the growth and availability of technology, including computerized testing.The current codes do not reflect the multiple standards of practice and therefore result in confusion about how to report the codes. The RUC recommended that the entire psychological and neuropsychological testing codes be referred to the CPT Editorial Panel for revision. CMS also requested that CPT code 96125 and 96127 be added to this family of services for revision/review. In September 2016, the CPT Editorial Panel created seven codes to differentiate technician administration of psychological testing and neuropsychological testing from physician/ psychologist administration and assessment of testing; and deleted codes 96101-96103, 96111, 96118, 96119, 96120.

Organizations representing psychiatry, psychology, neurology, pediatrics and speech pathologists conducted a survey for the January 2017 RUC and HCPAC Review Board meetings. During this effort, it became apparent that further CPT revisions are required. Survey respondents were unable to articulate the work at the 60 or 30 minute coding increments and there is significant concern regarding the duplication of pre and post work as several units of service would be reported. Therefore, the organizations submitted a letter to the CPT Editorial Panel and the RUC to rescind the coding changes summarized below for *CPT 2018*. The organizations will submit a new coding proposal for consideration at the June 2017 CPT Editorial Panel meeting for *CPT 2019*. **The RUC HCPAC Review Board supports referral to CPT.**

Physical Medicine and Rehabilitation Services (97010-97542)
Richard Rausch PT, MBA (APTA); Katie Jordan, OTD, OTR/L (AOTA); Jeremy Furniss, OTD, OTR/L, BCG, CDP (AOTA)

In February 2010, some of the physical medicine and rehabilitation services were identified through the RUC's High Volume Growth screen. Subsequently, some services were identified via the Codes Reported Together 75% of the Time screen and then by CMS via the High Expenditure screen. A CPT Workgroup

was formed to address coding for these services, but after several years it was determined by CMS that a new structure was not preferred.

In the NPRM for 2017, CMS indicated that a review of the valuation should move forward for the following codes: 97032, 97035, 97110, 97112, 97113, 97116, 97140, 97530, 97535 and G0283. Eleven codes were added as part of this family of services and were reviewed for work and practice expense at the January 2017 RUC HCPAC Review Board meeting.

For both work and practice expense presentation and discussion, the 19 codes that were surveyed were divided into four categories of similar services: supervised modalities (97012, 97014, 97016, 97018, 97022); attended modalities (97032, 97033, 97034, 97035); therapeutic procedures (97110, 97112, 97113, 97116, 97140); and ADL (97530, 97533, 97535, 97537, 97542). CPT code 97010 was not surveyed and was referred to CPT. HCPCS code G0283 was not surveyed and was instead crosswalked to a similar service.

A survey was conducted that resulted in 50 to 350 responses from physical therapists and occupational therapists to individual codes. In general, both the survey 25th percentile and median work relative value unit (RVU) were higher than the current work RVU. Although the specialties provided written compelling evidence for code groups, at the RUC HCPAC Review Board meeting, the RUC HCPAC Review Board required compelling evidence to be presented on a code-by-code basis. In most cases, the RUC HCPAC Review Board recommends the current work value.

In addition to considering compelling evidence for some of the codes, the RUC HCPAC Review Board also considered the typical number of services reported per session. CMS has previously provided data to that indicated a mean of 3.5 codes are reported per session. This mean value of 3.5 units is similar to data APTA provided to CMS in 2010 that showed a median value of 3.0 units based on a review of approximately 3.3 million claims for both Medicare and non-Medicare patient encounters from various practice settings. In developing its recommendations, the RUC HCPAC Review Board considered this information from CMS and the specialties that the typical patient would be scheduled for either a 45 minute or one hour session and typically 3 to 4 codes would be reported. For example, a patient may receive 2 units of 97110 *Therapeutic Exercise* and one modality. The RUC HCPAC Review Board used this information to ensure there was no duplication in the recommended pre or post service time for each individual code.

In most cases, the RUC HCPAC recommends the current work RVU. However, the RUC HCPAC Review Board accepted compelling evidence for some codes to recommend an increase to the survey 25th percentile.

Supervised Modalities

97010 ***Application of a modality to 1 or more areas; hot or cold packs***
CMS considers 97010 a bundled service and does not make a separate payment for the service. The organizations surveying this family indicated that they are considering deletion or revision of the code. **The RUC HCPAC Review Board recommends that 97010 be referred to the CPT Editorial Panel.**

97012 ***Application of a modality to 1 or more areas; traction, mechanical***
Survey responses from 95 physical therapists resulted in a 25th percentile work RVU of 0.39 and a median of 0.48. No compelling evidence was presented for this code. The RUC HCPAC Review Board recommends the current work RVU of 0.25, which is slightly less work than 97150 *Therapeutic procedure(s), group (2 or more individuals)* (work RVU = 0.29, total time = 10 minutes) and the same work as 29550 *Strapping; toes* (work RVU = 0.25, total time = 11 minutes). The HCPAC Review Board did not agree that the current total time of 15 minutes or the survey time of 25 minutes to be credible. The

HCPAC Review Board recommends that minimal pre and post time of 1 minute each (current time) is appropriate. The RUC HCPAC Review Board recommends the survey 25th percentile of 10 minutes intra-service time. The total time of 12 minutes aligns with the total time of 10 minutes for the key reference service 97150 and the corresponding work RVU of 0.25. **The RUC HCPAC Review Board recommends a work RVU of 0.25 and time (1/10/1) for 97012.**

97014 ***Application of a modality to 1 or more areas; electrical stimulation (unattended)***
Survey responses from 102 physical therapists resulted in a 25th percentile work RVU of 0.23 and a median of 0.30. No compelling evidence was presented for this code. The RUC HCPAC Review Board recommends the current work RVU of 0.18, which is the same work as 99211 *Office visit, established patient* (work RVU = 0.18, total time = 7 minutes). The RUC HCPAC Review Board did not agree that the current total time of 13 minutes or the survey time of 25 minutes to be credible. The RUC HCPAC Review Board recommends that minimal pre and post time of 1 minute each (current time) is required. The RUC HCPAC Review Board recommends the 25th percentile of 7 minutes intra-service time. The total time of 9 minutes aligns with the total time of 7 minutes for the key reference service 99211 and the corresponding work RVU of 0.18. **The RUC HCPAC Review Board recommends a work RVU of 0.18 and time (1/7/1) for 97014.**

97016 ***Application of a modality to 1 or more areas; vasopneumatic devices***
Survey responses from 50 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.25 and a median of 0.30. No compelling evidence was presented for this code. The RUC HCPAC Review Board recommends the current work RVU of 0.18, which is the same as 99211 *Office visit, established patient* (work RVU = 0.18, total time = 7 minutes). The RUC HCPAC Review Board did not agree that the current total time of 18 minutes or the survey time of 24 minutes to be credible. The RUC HCPAC Review Board recommends that minimal pre and post time of 1 minute each (current time) is required. The RUC HCPAC Review Board recommends the 25th percentile of 8 minutes intra-service time. The total time of 10 minutes aligns with the total time of 7 minutes for the key reference service 99211 and the corresponding work RVU of 0.18. **The RUC HCPAC Review Board recommends a work RVU of 0.18 and time (1/8/1) for 97016.**

97018 ***Application of a modality to 1 or more areas; paraffin bath***
Survey responses from 108 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.20 and a median of 0.30. No compelling evidence was presented for this code. The HCPAC Review Board recommends the current work RVU of 0.06, which is less work than any of the unattended modality codes and significantly less than 99211 *Office visit, established patient* (work RVU = 0.18, total time = 7 minutes). The RUC HCPAC Review Board did not agree that the current total time of 13 minutes or the survey time of 22 minutes to be credible. The RUC HCPAC Review Board recommends that minimal pre and post time of 1 minute each (current time) is required. The RUC HCPAC Review Board recommends the 25th percentile of 8 minutes intra-service time. **The RUC HCPAC Review Board recommends a work RVU of 0.06 and time (1/8/1) for 97018.**

97022 ***Application of a modality to 1 or more areas; whirlpool***
Survey responses from 62 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.29 and a median of 0.35. No compelling evidence was presented for this code. The RUC HCPAC Review Board recommends the current work RVU of 0.17, which is similar to 99211 *Office visit, established patient* (work RVU = 0.18, total time = 7 minutes). The RUC HCPAC Review Board did not agree that the current total time of 15 minutes or the survey time of 25 minutes to be credible. The RUC HCPAC Review Board recommends that minimal pre and post time of 1 minute each (current time) is required. The RUC HCPAC Review Board recommends the 25th percentile of 12 minutes intra-service time. The total time of 14 minutes aligns with the total time of 12 minutes for 11719 *Trimming of nondystrophic nails, any numbe*r and work RVU of 0.17. **The RUC HCPAC Review Board recommends a work RVU of 0.17 and time (1/12/1) for 97022.**

Attended Modalities

97032 ***Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes***
Survey responses from 77 physical therapists resulted in a 25th percentile work RVU of 0.40 and a median of 0.48. No compelling evidence was presented for this code. The RUC HCPAC Review Board recommends the current work RVU of 0.25, which accounts for more work and time than 99211 *Office visit, established patient* (work RVU = 0.18, total time = 7 minutes). The code describes 15 minutes of attendance, therefore, the survey intra-time of 15 minutes is credible. The RUC HCPAC Review Board recommends minimal pre-time of 1 minute and post-time of 2 minutes to ensure no duplication when reported with other services. To justify the work RVU of 0.26, the RUC HCPAC Review Board referenced CPT code 97598 *Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure*) (work RVU=0.24, total time = 14 minutes) and code 29550 *Strapping; toes* (work RVU = 0.25, total time = 11 minutes). **The RUC HCPAC Review Board recommends a work RVU of 0.25 and time (1/15/2) for 97032.**

97033 ***Application of a modality to 1 or more areas; iontophoresis, each 15 minutes***
Survey responses from 87 physical therapists resulted in a 25th percentile work RVU of 0.27 and a median of 0.37. No compelling evidence was presented for this code. The HCPAC Review Board recommends the current value of 0.26, which is more work than 99211 *Office visit, established patient* (work RVU = 0.18, total time = 7 minutes). The code describes 15 minutes of attendance, therefore, the survey intra-time of 12 minutes is credible. The RUC HCPAC Review Board recommends minimal pre-time of 1 minute and post-time of 2 minutes to ensure no duplication when reported with other services. To justify the work RVU of 0.26, the RUC HCPAC Review Board referenced CPT code 97598 *Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure*) (work RVU=0.24, total time = 14 minutes) and code 29550 *Strapping; toes* (work RVU = 0.25, total time = 11 minutes). **The RUC HCPAC Review Board recommends a work RVU 0f 0.26 and time (1/12/2) for 97033.**

97034 ***Application of a modality to 1 or more areas; contrast baths, each 15 minutes***
Survey responses from 64 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.25 and a median of 0.33. No compelling evidence was presented for this code. The RUC HCPAC Review Board recommends the current value of 0.21, which is more work than 99211 *Office visit, established patient* (work RVU = 0.18, total time = 7 minutes). The code describes 15 minutes of attendance, therefore, the survey intra-time of 15 minutes is credible. The HCPAC Review Board recommends minimal pre-time of 1 minute and post-time of 2 minutes to ensure no duplication when reported with other services. The service is similar in work to 29550 *Strapping; toes* (work RVU = 0.25, total time = 11 minutes). **The RUC HCPAC Review Board recommends a work RVU of 0.21 and time (1/15/2) for 97034.**

97035 ***Application of a modality to 1 or more areas; ultrasound, each 15 minutes***
Survey responses from 105 physical therapists resulted in a 25th percentile work RVU of 0.30 and a median of 0.35. No compelling evidence was presented for this code. The RUC HCPAC Review Board recommends the current value of 0.21, which is more work than 99211 *Office visit, established patient* (work RVU = 0.18, total time = 7 minutes). The code describes 15 minutes of attendance, therefore, the survey intra-time of 10 minutes is credible. The RUC HCPAC Review Board recommends minimal pre-

time of 1 minute and post-time of 2 minutes to ensure no duplication when reported with other services. The service is similar in work to 29550 *Strapping; toes* (work RVU = 0.25, total time = 11 minutes). **The RUC HCPAC Review Board recommends a work RVU of 0.21 and time (1/10/2) for 97035.**

Therapeutic Procedures

97110 ***Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility***
Survey responses from 352 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.45 and a median of 0.50. The specialties did not ask for an increase in work RVU, therefore no compelling evidence was presented for this code. The HCPAC Review Board recommends the current work RVU of 0.45, which is also the survey 25th percentile. The code describes 15 minutes of direct one-on-one therapeutic exercise, therefore the survey intra-time of 15 minutes is credible. The RUC HCPAC Review Board reduced the specialty recommended pre- and post-time to a minimal pre-time of 2 minutes and post-time of 2 minutes to ensure no duplication when reported with other services. The RUC HCPAC Review Board determined that code 97110 was less work than key reference code 99212 *Office visit, established patient* (work RVU = 0.48, 2 minutes pre-service time, 10 minutes intra-service time and 4 minutes post-service time). To justify a work RVU of 0.45, the RUC HCPAC Review Board referenced code 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes* (work RVU = 0.45, total time =17). **The RUC HCPAC Review Board recommends a work RVU of 0.45 and time (2/15/2) for 97110.**

97112 ***Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities***
The RUC HCPAC Review Board agreed that compelling evidence had been met to consider an increase work RVU for this service. To summarize compelling evidence: Patients are referred to physical therapy earlier and are therefore more acute. Patient expectation for a quick and complete recovery has increased in the past decade. The knowledge requirements have increased (eg, Doctoral degree is now required for physical therapy) in concert with an expansion in technology.

Survey responses from 330 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.50 and a median of 0.60. The RUC HCPAC Review Board recommends a work RVU of 0.50, which is the survey 25th percentile. The code describes 15 minutes of direct one-on-one therapeutic neuromuscular reeducation, therefore the survey intra-time of 15 minutes is credible. The RUC HCPAC Review Board reduced the specialty recommended pre- and post-time to a minimal pre-time of 2 minutes and post-time of 2 minutes to ensure no duplication when reported with other services. The RUC HCPAC Review Board determined that code 97112 is service is similar in work to 99212 *Office visit, established patient* (work RVU = 0.48, 2 minutes pre-service time, 10 minutes intra-service time, and 4 minutes post-service time); and code 99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (work RVU = 0.50, total time = 15 minutes); and 97112 is also similar in work to 29125 *Application of short arm splint (forearm to hand); static* (work RVU = 0.50, 5 minutes pre-service time, 15 minutes intra-service time and 3 minutes post-service time). **The RUC HCPAC Review Board recommends a work RVU of 0.50 and time (2/15/2) for 97112.**

97113 ***Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises***
The RUC HCPAC Review Board agreed that compelling evidence had been met to consider an increase work RVU for this service. To summarize compelling evidence: Patients are referred to physical therapy earlier and are therefore more acute. Patient expectation for a quick and complete recovery has increased in the past decade. The knowledge requirements have increased (eg, Doctoral degree is now required for

physical therapy) in concert with an expansion in technology. Risk of falls and water safety also make the service more intense relative to other therapeutic procedures.

Survey responses from 76 physical therapists resulted in a 25th percentile work RVU of 0.48 and a median of 0.52. The HCPAC recommends a work RVU of 0.48, which is the 25th percentile of this survey. The code describes 15 minutes of direct one-on-one aquatic therapy with therapeutic exercise, therefore the survey intra-time of 15 minutes is credible. The RUC HCPAC Review Board reduced the specialty recommended pre- and post-time to a minimal pre-time of 2 minutes and post-time of 2 minutes to ensure no duplication when reported with other services. The RUC HCPAC Review Board determined that 97113 is similar in work to 99212 *Office visit, established patient* (work RVU = 0.48, time = 2 minutes pre-service time, 10 minutes intra-service time and 4 minutes post-service time) and CPT code 99201 *Office visit, new patient* (work RVU = 0.48, total time = 17 minutes); and code 92542 *Positional nystagmus test, minimum of 4 positions, with recording* (work RVU = 0.48, total time = 16 minutes). 97113 is also similar in work to 29125 *Application of short arm splint (forearm to hand); static* (work RVU = 0.50, 5 minutes pre-service time, 15 minutes intra-service time, 3 minutes post-service time). **The RUC HCPAC Review Board recommends a work RVU of 0.48 and time (2/15/2) for 97113.**

97116 ***Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)***
The RUC HCPAC Review Board agreed that compelling evidence had been met to consider an increase work RVU for this service. To summarize compelling evidence: Patients are referred to physical therapy earlier and are therefore more acute. Patient expectation for a quick and complete recovery has increased in the past decade. The knowledge requirements have increased (eg, Doctoral degree is now required for physical therapy) in concert with an expansion in technology.

Survey responses from 168 physical therapists resulted in a 25th percentile work RVU of 0.48 and a median of 0.52. The HCPAC did not agree with the specialty's recommendation of 0.48 and instead recommends a work RVU of 0.45, which is less than the 25th percentile of the survey and equal to the recommendation for 97110. The code describes 15 minutes of direct one-on-one gait training, therefore the survey intra-time of 15 minutes is credible. The RUC HCPAC Review Board reduced the specialty recommended pre- and post-time to a minimal pre-time of 2 minutes and post-time of 2 minutes to ensure no duplication when reported with other services. The RUC HCPAC Review Board determined code 97116 should be valued slightly less than key reference code 99212 *Office visit, established patient* (work RVU = 0.48, total time = 16 minutes). To justify a work RVU of 0.45, the RUC HCPAC Review Board referenced code 97803 Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes (work RVU = 0.45, total time = 17 minutes). 97112 is also similar in work to 29125 *Application of short arm splint (forearm to hand); static* (work RVU = 0.50, 5 minutes pre-service time, 15 minutes intra-service time and 3 minutes post-service time). The RUC HCPAC Review Board recommends that 97116 be valued the same as 97110 and determined that a crosswalked to CPT code 93016 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report (work RVU = 0.45; 2 minutes pre-service time, 15 minutes intra-service time, 2 minutes post-service time) was acceptable.* ***The RUC HCPAC Review Board recommends a work RVU of 0.45 and time (2/15/2) for 97116.***

97140 ***Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes***
Survey responses from 284 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.50 and a median of 0.67. The RUC HCPAC Review Board did not accept compelling evidence to increase the value of the code. The RUC HCPAC Review Board recommends the current work RVU of 0.43 be retained. The code describes 15 minutes of direct one-on-one manual therapy techniques, therefore the survey intra-time of 15 minutes is credible. The RUC HCPAC Review Board reduced the specialty recommended pre- and post-time to a minimal pre-time of 2 minutes and post-time

of 2 minutes to ensure no duplication when reported with other services. The service is similar in work to 99212 *Office visit, established patient* (work RVU = 0.48, 2 minutes pre-service time, 10 minutes intra-service time and 4 minutes post-service time). **The RUC HCPAC Review Board recommends a work RVU of 0.43 and time (2/15/2) for 97140.**

ADL

97530 ***Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes***
Survey responses from 347 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.48 and a median of 0.55. The RUC HCPAC Review Board did not accept compelling evidence to increase the value of the code. The HCPAC Review Board recommends the current value of 0.44 be retained. The code describes 15 minutes of direct one-on-one therapeutic activities, therefore the survey intra-time of 15 minutes is credible. The RUC HCPAC Review Board reduced the specialty recommended pre- and post-time to a minimal pre-time of 2 minutes and post-time of 2 minutes to ensure no duplication when reported with other services. The service is similar in work to 99212 *Office visit, established patient* (work RVU = 0.48, 2 minutes pre-service time, 10 minutes intra-service time and 4 minutes post-service time). **The RUC HCPAC Review Board recommends a work RVU of 0.44 and time (2/15/2) for 97530.**

97533 ***Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes***
The RUC HCPAC Review Board agreed that compelling evidence had been met to consider an increase work RVU for this service. To summarize compelling evidence: Patients are referred to physical therapy earlier and are therefore more acute. The typical patient for this service is a child and as children are being identified at a much younger age, the intensity and complexity of the work has increased, along with additional therapists education requirements.

Survey responses from 136 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.48 and a median of 0.55. The RUC HCPAC recommends a value of 0.48, which is the 25th percentile of this survey. The code describes 15 minutes of direct one-on-one sensory integrative therapy, therefore the recommended intra-time of 15 minutes is credible. Code 97533 is typically reported with 2 units as the therapist will typically spends 30 minutes with the child. The survey indicated that the session would include pre-service time of 6 minutes; intra-time service time of 30 minutes; and post-service time of 10 minutes. The RUC HCPAC Review Board recommends 3 minutes pre-service time, 15 minutes intra-service time and 5 minutes post-service time as the appropriate time per unit of service as two units are typically reported. A single unit of 97533 is similar in work to 99212 *Office visit, established patient* (work RVU = 0.48, 2 minutes pre-service time, 10 minutes intra-service time and 4 minutes post-service time). To justify a work RVU of 0.48, the RUC HCPAC Review Board referenced code 96151 *Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment* (work RVU = 0.48, total time = 24 minutes); and code 97533 is also similar in work to 29125 *Application of short arm splint (forearm to hand); static* (work RVU = 0.50, 5 minutes pre-service time, 15 minutes intra-service time and 3 minutes post-service time). **The RUC HCPAC Review Board recommends a work RVU of 0.48 and time (3/15/5) for 97533.**

97535 ***Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes***
Survey responses from 242 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.48 and a median of 0.55. The RUC HCPAC Review Board did not accept compelling evidence to increase the value of the code. The RUCHCPAC Review Board recommends the current

value of 0.45 be retained. The code describes 15 minutes of direct one-on-one self-care/home management training, therefore the recommended intra-time of 15 minutes is credible. The HCPAC Review Board recommends minimal pre-time of 2.5 minutes and post-time of 4 minutes to ensure no duplication when reported with other services. The typical patient for this service is not a Medicare beneficiary. Two units of service is typically reported, therefore the survey time of 5 minutes pre and 8 minutes post were appropriately divided by two units. The service is similar in work to 99212 *Office visit, established patient* (work RVU = 0.48, 2 minutes pre-service time, 10 minutes intra-service time and 4 minutes post-service time). **The RUC HCPAC Review Board recommends a work RVU of 0.45 and time (2.5/15/4) for 97535.**

97537 ***Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes***
The RUC HCPAC Review Board agreed that compelling evidence had been met to consider an increase work RVU for this service. To summarize compelling evidence: Patients are referred to physical therapy earlier and are therefore more acute. Patient expectation for a quick and complete recovery has increased in the past decade. Patients expect to remain independent in their home instead of being cared for at a facility.

Survey responses from 127 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.48 and a median of 0.55. The RUC HCPAC Review Board recommends a value of 0.48, which is the 25th percentile of this survey. The code describes 15 minutes of community/work reintegration training, therefore, the survey intra-time of 15 minutes is credible. Code 97537 is typically reported with 2 units as the therapist typically spends 30 minutes with the patient. The survey indicated that the session would be pre-service time of 10 minutes; intra-service time of 30 minutes; and post–service time of 10 minutes. The RUC HCPAC Review Board recommends 5 minutes pre-service time, 15 minutes intra-service time and 5 minutes post-service time as the appropriate time per unit of service as two units are typically reported. One unit of the service is similar in work to 99212 *Office visit, established patient* (work RVU = 0.48, 2 minutes pre-service time, 10 minutes intra-service time and 4 minutes post-service time). To justify a work RVU of 0.48, the HCPAC Review Board referenced code 96151 *Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment* (work RVU = 0.48, total time = 24 minutes); and code 29125 *Application of short arm splint (forearm to hand); static* (work RVU = 0.50, 5 minutes pre-service time, 15 minutes intra-service time and 3 minutes post-service time). **The RUC HCPAC Review Board recommends a work RVU of 0.48 and time (5/15/5) for 97537.**

97542 ***Wheelchair management (eg, assessment, fitting, training), each 15 minutes***
The HCPAC Review Board agreed that compelling evidence had been met to increase the value for these services as the equipment has dramatically changed over the past decade. Medicare documentation of medical necessity requirements increased substantially, requiring that mobility related activities of daily living and the patient be thoroughly assessed and documented to justify every component of a complex wheelchair. This has resulted in more intense and complex therapist work.

Survey responses from 149 physical therapists and occupational therapists resulted in a 25th percentile work RVU of 0.48 and a median of 0.60. The HCPAC Review Board recommends a work RVU of 0.48, which is the survey 25th percentile. The code describes 15 minutes of direct one-on-one wheelchair management, therefore, the survey intra-time of 15 minutes is credible. Code 97542 is typically reported with 2 units as the therapist typically spends 30 minutes with the patient. The survey indicated that the session would include pre-service time of 6 minutes and post–service time of 10 minutes. The HCPAC Review Board recommends 3 minutes pre-service time, 15 minutes intra-service time and 5 minutes post-service time (one-half the survey time) as the appropriate pre and post-time per unit of service. The

service is similar in work to 99212 *Office visit, established patient* (work RVU = 0.48, 2 minutes pre-service time, 10 minutes intra-service time and 4 minutes post-service time). 97533 is also similar in work to 29125 *Application of short arm splint (forearm to hand); static* (work RVU = 0.50, 5 minutes pre-service time, 15 minutes intra-service time and 3 minutes post-service time). **The RUC HCPAC Review Board recommends a work RVU of 0.48 and time (3/15/5) for 97542.**

G0283 ***Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care***
The specialties indicated that CMS generated code G0283 to track a new benefit to report electrical stimulation that is utilized for wounds versus non-wound treatment (reported with code 97014). When CMS created code G0283, they crosswalked the work value and PE details from code 97014. The HCPAC Review Board agrees with the specialties that this relationship is correct and should be maintained. **The RUC HCPAC Review Board recommends a work RVU of 0.18 and time (1/7/1) for G0283, which is crosswalked from the HCPAC Review Board recommendation for 97014.**

Practice Expense
The practice expense inputs were reviewed with the understanding that the multiple procedure payment reduction (MPPR) of 50% is in place for the practice expense component for the second and subsequent reporting of a physical medicine and rehabilitation service on the same date of service. The organizations confirmed that it is typical to bill two units of these services in one session. The PE Subcommittee adjusted the clinical staff time where appropriate to account for the MPPR reduction that would occur when two of more units were reported so that clinical staff time was not over-reported or under-reported. The supplies were reviewed in great detail to ensure accuracy and were adjusted to account for the typical units billed and MPPR reductions in a similar fashion to the clinical staff time recommendations. The equipment time was updated to conform to the CMS formula and standards.

RUC Database Notation
The supervised modalities will be marked "Do not use to validate for work" as the current database time and survey time estimates were not accepted by the RUC HCPAC Review Board as credible. The note will be appended to CPT codes 97012, 97014, 97016, 97018 and 97022 in the RUC database.

Orthotic Management and Prosthetic Training (97760, 97761 and 97763)
Katie Jordan, OTD, OTR/L (AOTA); Jeremy Furniss, OTD, OTR/L, BCG, CDP (AOTA); Richard Rausch, PT, MBA (APTA)

CPT Codes 97760-97761, describing orthotic and prosthetic management and training, were identified as part of the larger family of physical medicine and rehabilitation services to be reviewed as potentially misvalued services due to high expenditure and high volume growth screens. The physical and occupational therapists requested coding revisions to these codes to differentiate more properly between the initial and subsequent encounters and to better describe the ongoing management and/or training that is involved with subsequent encounters.

97760 ***Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes***
The HCPAC reviewed the survey results from more than 100 respondents and recommends the survey 25th percentile work RVU of 0.50 for CPT code 97760. The respondents, however, appeared to respond to the time questions by considering the entirety of the visit (10 minutes pre-time, 30 minutes intra-service time and 10 minutes immediate post-service time) for two units of service. The HCPAC agreed that the appropriate time for the code should be divided by two and reflect 5 minutes pre-time, 15 minutes intra-service time and 5 minutes immediate post-service time, for each unit of service. The HCPAC approved compelling evidence to increase the current value of CPT code 97760 from 0.45 to the 25th percentile of

0.50, as the orthotics have become more dynamic and customized (new technology) since the previous evaluation. The HCPAC determined that CPT code 97760 is equivalent in work to CPT Code 29125 *Application of short arm splint (forearm to hand); static* (work RVU = 0.50 and 5 minutes pre-time, 15 minutes intra-service time and 3 minutes immediate post-service time). **The RUC HCPAC Review Board recommends a work RVU of 0.50 and time (5/15/5) for CPT code 97760.**

97761 ***Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes***

The HCPAC reviewed the survey results from more than 50 respondents and recommends the survey 25th percentile work RVU of 0.50 for CPT code 97761. The respondents, however, appeared to respond to the time questions by considering the entirety of the visit (10 minutes pre-time, 30 minutes intra-service time and 10 minutes immediate post-service time), for two units of service. The HCPAC agreed that the appropriate time for the code should be divided by two and reflect 5 minutes pre-time, 15 minutes intra-service time and 5 minutes immediate post-service time, for each unit of service. The HCPAC approved compelling evidence to increase the current value of CPT code 97761 from 0.45 to the 25th percentile of 0.50, as the orthotics have become more dynamic and customized (new technology) since the previous evaluation. Patient expectation has also greatly increased over the past decade. The HCPAC determined that CPT code 97761 is equivalent in work to CPT Code 29125 *Application of short arm splint (forearm to hand); static* (work RVU = 0.50 and 5 minutes pre-time, 15 minutes intra-service time and 3 minutes immediate post-service time). **The RUC HCPAC Review Board recommends a work RVU and time (5/15/5) of 0.50 for CPT code 97761.**

97763 ***Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes***

The HCPAC reviewed the survey results from nearly 90 respondents and recommends the 25th percentile work RVU of 0.48 for CPT code 97763. The respondents, however, appeared to respond to the time questions by considering the entirety of the visit (5 minutes pre-time, 20 minutes intra-service time and 10 minutes immediate post-service time), for two units of service. The HCPAC agreed that the appropriate time for the code should be divided by two for pre/post and reflect 15 minutes for intra-service time, which is aligns with the code descriptor. The HCPAC recommends 2.5 minutes pre-service time, 15 minutes intra-service time and 5 minutes immediate post-service time, for each unit of service. The HCPAC approved compelling evidence to increase the current value of the deleted code 97762 from 0.25 to the 25th percentile of 0.48, as the orthotics and prosthetics have become more dynamic and customized (new technology) since the previous evaluation. Additionally, patients are treated much earlier and are more acute. The HCPAC noted that CPT code 97763 is similar in work to CPT code 29125 *Application of short arm splint (forearm to hand); static* (work RVU = 0.50, 5 minutes pre-time, 15 minutes intra-service time and 3 minutes immediate post-service time). The HCPAC agreed that the subsequent visit is very similar in work to the initial visit as the orthotics and prosthetics are now customized. The previous code 97762 described a simple re-check of a static orthotic/prosthetic. **The RUC HCPAC Review Board recommends a work RVU and time (2.5/15/5) of 0.48 for CPT code 97763.**

Practice Expense

The practice expense inputs were reviewed with the understanding that the multiple procedure payment reduction of 50% is in place for the practice expense component for the second and subsequent reporting of a physical medicine and rehabilitation service on the same date of service. The specialty society confirmed that it is typical to bill for two units of these services. The clinical staff time for 97760, 97761 and 97763 have all been reduced from the current inputs. The supplies were reviewed in great detail to ensure accuracy and were adjusted to account for the typical units billed. The equipment time has been updated to conform to the proper formula and standards.

Application of Surface Neurostimulator (64550)
Katie Jordan, OTD, OTR/L (AOTA)

In September 2016, the CPT Editorial Panel deleted code 64565 to report percutaneous placement of a neuromuscular neurostimulator electrode, and added parenthetical notes to direct users to report the appropriate codes for TENS, PENS, and PNT services throughout the family of codes. Transcutaneous electrical nerve stimulator (TENS) is an electronic device that applies electrical stimulation to the surface of the skin at the site of pain and has been used to relieve chronic intractable pain, post-surgical pain, and pain associated with active or post-trauma injury unresponsive to other standard pain therapies. TENS consist of an electrical pulse generator, usually battery operated, connected by wire to two or more electrodes, which are applied to the surface of the skin at the site of the pain. Occupational Therapy has been identified as the dominant provider of CPT code 64550, however occupational therapy practitioners indicated it is not the best practice for TENS to be used for occupational therapy interventions and as such do not have evidence base in the profession. Occasionally a trial of TENS is done in the clinic over 1-2 therapy visits and, if the patient has had a favorable response, the patient can usually be taught to use a TENS unit in the home for pain control (TENS units are available in drug stores for purchase). Consequently, it is unnecessary for a patient to continue treatment for pain with a TENS unit in the clinic setting. Use of this code would seldom fall under a therapy plan of treatment. The occupational therapy specialty believes that occupational therapists have reported CPT code 64550 in error. Two other codes exist that relate to electric stimulation and are more frequently reported by occupational therapy and are valued the same as 64550:

1. CPT 97014/G0283, supervised electric stimulation and
2. CPT 97032, attended manual electric stimulation.

CPT 97014/G0283 is appropriate for pad-based e-stimulation, which requires supervision only. CPT code 97014 Application of a modality to one or more areas; electrical stimulation (unattended) is an invalid code for Medicare which requires that G0283 be reported. CPT 97032 can only be used when stimulation is manually applied. The requirement for constant attendance is derived from the manual-application requirement and is based on different stimulation frequencies necessitating one-on-one supervision. Additionally, CPT codes 64550 and 97032 each have an identical work value of 0.18 RVU which indicates that both codes have been identified as requiring the same amount of therapist work.

The AMA RUC Health Care Professionals Advisory Committee (HCPAC) refers CPT code 64550 to the CPT Editorial Panel and recommends that the code be deleted. Additionally, the HCPAC recommends that instructions following the deleted code 64550 should direct users to instead report 97032 for electrical stimulation requiring constant attendance or 97014 for electrical stimulation requiring supervision only.

The RUC filed the HCPAC Report.

XIII. Relativity Assessment Workgroup (Tab 30)

- **Action Plan Review**
  Doctor Hitzeman summarized the Relativity Assessment Workgroup report and indicated that the Workgroup resolved a work neutrality issue it had reviewed a couple times. After correcting the 2011 interim final work RVUs the split for CPT codes 57155 and 57156 **the Workgroup determined that codes 57155 and 57156 are being reported appropriately and to remove from further review under this work neutrality examination.**

  The Workgroup reviewed another code set that had been recommended for a bundling solution for codes 22558 and 63090. Previously, the specialty societies reviewed CPT coding guidelines

and educational materials for 63090 and believe 63090 may have been inappropriately reported with 22558 because there is no definition for partial vertebral corpectomy in CPT. In September 2016, the CPT Editorial Panel added introductory language to the guidelines defining partial vertebral corpectomy. The 2014 Medicare data indicate that 22558 and 63090 are reported together 72% of the time. The Workgroup reviewed the recent action plan addressing whether a bundling solution is still necessary or if the education and coding guideline changes address CPT codes 22558. The specialty societies indicated that the utilization for 63090 should decrease significantly after the CPT 2018 changes and should be reviewed after additional data is available. **The Workgroup agreed that codes 22558 & 63090 reported together are decreasing and recommend that the Workgroup review the reported together data after the 2018 changes are in effect and two years of data are available (October 2022).**

- **High Volume Codes**
  Doctor Hitzeman indicated that the Workgroup continued review of services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2009 through 2014. The query resulted in the identification of 11 services. **The Relativity Assessment Workgroup reviewed the action plans submitted by the specialty societies and recommends the following:**

CPT Code	Recommendation
00537	Review additional utilization data in two years (October 2019). Notify the Anesthesia Workgroup that this is a high growth service.
01936	Request that the specialty society research data on what procedures are reported with this anesthesia code. Review action plan in April 2017.
31623	Survey April 2017.
64450	Request the specialty societies review this issue further to determine if there are any other peripheral nerves or branches not specified with a CPT code to determine if this service may be deleted. Review action plan April 2017.
64455	Currently on LOI to survey for April 2017 as identified by CMS in the 000-day global service typically reported with an E/M screen.
77435	Remove from screen. This service has been consistently reviewed by the RUC and PE Subcommittee since their creation (2011) and the growth remains modest.
77523	This service is carrier priced and determined appropriate. Remove from screen.
78492	Refer to CPT Editorial Panel to undergo substantive descriptor changes to reflect newer technology aspects such as wall motion, ejection fraction, flow reserve, and technology updates for hardware and software. CPT 2019 cycle.
93571	Survey October 2017.
95951	Refer to CPT Editorial Panel June 2017/RUC Oct 2017 for needed changes, including code deletions, revision of code descriptors, and the addition of new codes to this family. Revisions to this family of codes are needed to recognize that video is now an element of most long term EEG monitoring tests and to better differentiate inpatient and ambulatory monitoring services.
G0102	Remove from screen. This is a federally mandated carve-out service of the exam that is otherwise included in preventive medicine CPT codes such as 99397.

- **Final Rule – 000-Day Global Services Reported with an E/M with Modifier 25**
  In the NPRM for 2017 CMS identified 83 services with a 000-day global period billed with an E/M 50 percent of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000.

  The RUC commented that it appreciated CMS' identification of an objective screen and reasonable query. However, based on further analysis of the codes identified, it appears only 19 services met the criteria for this screen and have not been reviewed to specifically address an E/M performed on the same date. There were 38 codes that did not meet the screen criteria; they were either reviewed in the last 5 years and/or are not typically reported with an E/M. For 26 codes, the summary of recommendation (SOR), RUC rationale or practice expense inputs submitted specifically states that an E/M is typically reported with these services and the RUC accounted for this in its valuation.
  The RUC requested that CMS remove 64 services that did not meet the screen criteria or which have already been valued as typically being reported with an E/M service. The RUC requested that CMS condense and finalize the list of services for this screen to the 19 remaining services.

  In the Final Rule for 2017, CMS did finalize the list of 000-day global services reported with an E/M to the 19 services that truly met the criteria. The 19 services CMS identified that have not been reviewed as typically being reported with an E/M service will be placed on the next Level of Interest (LOI) form for survey and presentation at the April 2017 RUC meeting.

  At this meeting, AAOS, ASSH and APMA noticed that the RUC database did not have the vignette shown for CPT code 20612, but instead the intra-service work was inserted in the vignette cell. Upon review of the summary of recommendation for 20612, and in addition code 20526 which was also on the CMS list, both presented at the April 2002 meeting, the specialty societies discovered that in fact an E/M as typical was considered in the survey process; the survey vignettes had a "note" directing the survey respondents to NOT include E/M work when completing the survey. **The specialty societies recommend and the Workgroup agreed that CPT codes 20612 and 20526 should be removed from this screen since the valuation for these services already excludes any E/M with this service. The Workgroup recommends that CMS remove codes 20612 and 20526 from this screen and the RUC database be revised to include the correct vignettes for codes 20612 and 20526.**

- **Joint CPT/RUC Codes Reported Together Frequently Workgroup Report**
  Doctor Krol presented the Joint Workgroup report and indicated that the Workgroup reviewed four specific code bundle possibilities and determined that the reporting together of these services have already been addressed or a code bundle solution is not necessary. **The full Joint CPT/RUC Codes Reported Together Frequently Workgroup report is attached to these minutes.**

  The full Relativity Assessment Workgroup report is attached to these minutes. The RUC approved the Relativity Assessment Workgroup Report.

XIV. Research Subcommittee (Tab 31)

Doctor Doug Leahy, Chair, provided a summary of the Research Subcommittee report:

- **The Subcommittee reviewed and accepted the October 2016 Research Subcommittee conference call report.**

- **RUC Survey Physician Time Question – Precision of physician time data**

  At the December 2015 Time-Intensity Workgroup meeting, as part of a discussion on measuring physician time, several Workgroup members noted that survey results often appear that the survey respondents tend to round to the nearest 5 minute or 15 minute increment instead of providing estimates to the nearest minute. The Research Subcommittee discussed this issue in April, though referred it to the Time-Intensity Workgroup for further discussion.

  At the October meeting, the Time-Intensity Workgroup discussed this issue in detail. The Time-Intensity Workgroup recommended for the question text to be modified as follows:

  > **Question 2 (from RUC Online Survey Tool):** How much of your own time is required per patient treated for each of the following steps in patient care related to this procedure? **It is important to be as precise as possible. For example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes.** *Indicate your time for the survey code(s) (in minutes) in each box below. If you do zero minutes for one of the below time components, then you would need to put 0.*
  >
  > *Please refer to the information above for a list of definitions.*

  The Research Subcommittee discussed the above modified language and agreed that the proposed language may potentially result in more specificity of survey time data. **The Research Subcommittee approved for the new language to be added to all standard RUC survey templates.** The Subcommittee also requested for AMA staff to conduct an analysis once possible to attempt to determine whether the change has had any impact.

- **Requirement to Present Summary Data to RUC if Survey is Conducted**

  In 2014, a RUC member brought up a concern regarding the current ability for specialty societies to conduct a survey and then request to resurvey, without ever having to submit a summary of the original survey data to the RUC. The RUC member proposed that if a survey is conducted, then a summary of the original data would need to be submitted to the RUC. This issue was referred to the Research Subcommittee and discussed at the September 2014 meeting. The Research Subcommittee did not recommend the adoption of the proposal at that time. Instead, the Subcommittee requested for AMA staff to track the occurrences and will re-evaluate the issue in two years, at the October 2016 meeting.

  At the October 2016 meeting, AMA staff noted that in addition to the table showing the history of how often societies requested resurvey without providing a summary of their original data, there were a similar number of instances where societies requested resurvey but did provide summary data. The Research Subcommittee decided to table this issue for the January 2017 meeting and for AMA staff to provide historical information which also showed when societies requested resurvey but also provided the summary data.

  At the January 2017 meeting, the Subcommittee reviewed the updated information provided by staff and noted that this seems to be a relatively uncommon issue and that there does not seem to be any pattern. Several Subcommittee members noted that the most common rationale was due to societies referring codes to CPT after discovering something after launching their surveys. The Subcommittee agreed that no rule was needed at this time and also noted that they could revisit the issue in two years to continue to track this issue.

- **Review of Suggestion from Time-Intensity Workgroup regarding Survey Intensity and Complexity Questions**

  As part of its discussion of the intensity and complexity measures, the Time-Intensity Workgroup observed that in addition to the overall intensity question, there are currently 8 other component questions which seems too granular. Several Workgroup members noted that the intensity and complexity questions should be collapsed into fewer questions. One Workgroup member suggested that the three Mental Effort and Judgment questions and the three psychological stress questions should each be collapsed into a single question, respectively. Several Workgroup members noted their belief that this would help improve survey response rates while also providing a sufficient amount of data for the RUC to review. The Time-Intensity Workgroup recommended for the Research Subcommittee to consider only having five total intensity and complexity questions: Mental Effort and Judgment, Technical Skill, Physical Effort, Psychological stress and Overall intensity. Also, the Workgroup recommends for the definitions for each component of intensity and complexity to remain unchanged.

  The Research Subcommittee approved the Time-Intensity Workgroup's recommendation, to collapse the three mental effort and judgment and three psychological stress intensity and complexity questions each into a single question. The Subcommittee requested for AMA Staff to draft updated survey language for its consideration at the April 2017 RUC meeting.

  Separately, a Subcommittee member also proposed for the Subcommittee to consider replacing the old Intensity and complexity summary ratings in the Summary of Recommendations form with the new Intensity and Complexity percent distribution measures (currently included in the "Intensity & Complexity Addendum"). Another Subcommittee member noted that an AMA Economist who attended the Time-Intensity Workgroup session at the October 2016 meeting had noted that certain aspects of the old summary data methodology was not appropriate (ie assigning text answers arbitrary numeric values and then averaging those values). **The Subcommittee approved for the new Time-Intensity Measures to be incorporated into the Summary of Recommendation form, replacing the old measures:**

<table>
<tr><td colspan="2"></td><td colspan="3">Survey Code Compared to Top Ref Code</td></tr>
<tr><td colspan="2" rowspan="2">Overall Intensity and Complexity:</td><td colspan="3">Survey Code is:</td></tr>
<tr><td>
<table>
<tr><th>Much Less</th><th>Somewhat Less</th><th>Identical</th><th>Somewhat More</th><th>Much More</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td rowspan="2">Mental Effort and Judgment:</td><td>The number of possible diagnosis and/or number of management options that must be considered</td><td colspan="3">
<table>
<tr><th>Less</th><th>Identical</th><th>More</th></tr>
<tr><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed</td><td colspan="3">
<table>
<tr><th>Less</th><th>Identical</th><th>More</th></tr>
<tr><td></td><td></td><td></td></tr>
</table>
</td></tr>
</table>

	Urgency of medical decision making	**Less** / **Identical** / **More**
Technical Skill:		**Less** / **Identical** / **More**
Physical Effort:		**Less** / **Identical** / **More**
Psychological Stress:	**The risk of significant complications, morbidity and/or mortality**	**Less** / **Identical** / **More**
	Outcome depends on the skill and judgment of physician	**Less** / **Identical** / **More**
	Estimated risk of malpractice suite with poor outcome	**Less** / **Identical** / **More**

- **Request to conduct Proctored Survey during Society's Annual Meeting for Biopsy of Skin Lesion**

  American Academy of Dermatology Association

  The American Academy of Dermatology Association requested to perform a proctored survey for new biopsy of skin lesion codes for the April 2017 RUC meeting. Following a brief discussion, the Subcommittee did not approve a proctored survey for these services.

  The RUC approved the Research Subcommittee Report.

XV. Administrative Subcommittee (Tab 32)

- **Review Rotating Seat Candidates Nominated (Tab 34)**
  Doctor Waldorf noted that the Administrative Subcommittee reviewed the nominations for the "Any Other" rotating seat, David C. Han, MD, Society for Vascular Surgery and the internal medicine rotating seat, noting that the sole candidate had withdrawn and an additional nomination was submitted Friday, January 13th. Doctor Alnoor Malick, from the American College of Allergy, Asthma and Immunology (ACAAI) and the American Academy of Allergy, Asthma and Immunology (AAAAI), was elected.

- **Review Primary Care Rotating Seat Eligibility Criteria**
  Doctor Waldorf indicated the primary care rotating seat eligibility criteria requires documentation confirming candidates are defined as a primary care physician by Medicare or Medicaid. Documentation of one's primary care bonus eligibility was required. The Medicare primary care bonus ended in 2015 and can no longer be used to confirm primary care Medicare status.

  In October 2016, the Administrative Subcommittee reviewed the eligibility criteria and recommended revisions. After extensive discussion, the RUC determined that additional edits were necessary and postponed this issue until this meeting to discuss further.

The Administrative Subcommittee reviewed the Primary Care Rotating seat eligibility criteria and noted that the RUC's primary care rotating seat determination is based on the qualifications of the individual candidates nominated, not the specific appointing specialty society. **The Workgroup recommends the revised Primary Care rotating seat candidate eligibility requirement as follows:**

> Candidate Eligibility
>
> The RUC approved that subspecialties deemed eligible for the Internal Medicine or other rotating seats, may choose individuals that represent the interest of the subspecialty group and that a board certification in that particular specialty is not a requirement.
> The Primary Care rotating seat candidate must be in active clinical practice, with at least 50% of their professional time in direct patient care. The Primary Care rotating seat candidate must present documentation that he/she is defined as a primary care physician by Medicare or Medicaid and the candidates' evaluation and management services (excluding hospital inpatient care and emergency department visits) account for at least 60 percent of the practitioners total allowed charges under the physician fee schedule. The Primary Care rotating seat candidate must be a physician with significant experience and expertise in broad-based chronic disease management, comprehensive treatment plan development and management, and preventive care.

Doctor Waldorf noted that the Administrative Subcommittee received a letter of support regarding these revisions from the American Academy of Family Physicians, American Osteopathic Association and American Geriatrics Society.

- **Review RUC Compelling Evidence Standards**

Doctor Waldorf noted that in April 2016, A RUC member requested review of the compelling evidence standards regarding the definition and rules. The RUC member noted that when reviewing these standards, the Administrative Subcommittee should consider that in cases when a code is resurveyed and CMS did not accept previous recommended RUC value, compelling evidence based on flawed mechanism (CMS unilateral decision) can be used to recommend a value that is equal to the previous RUC recommended value, but additional compelling evidence would need to be presented if recommended value is higher than the previous recommended value.

In October 2016, the Subcommittee did not have time to address multiple items regarding adding compelling evidence standards for instances when CMS rejected a RUC recommended work RVU and a specialty society is coming back to the RUC with a higher work RVU than the CMS accepted value. The Subcommittee determined that it would discuss the addition of this language to the RUC Rules Regarding Presentation and Evaluation of Work Relative Values Compelling Evidence standards, as well as discuss adding other compelling evidence standards such as negative IWPUT at the January 2017 Administrative Subcommittee.

At this meeting, the Subcommittee determined that the existing "flawed mechanism or methodology" compelling evidence standard bullet already includes circumstances when a specialty society returns to the RUC with a recommendation that is the same as a RUC recommended value for a code in which CMS finalized lower than the RUC recommended value. Therefore, if a specialty society is presenting a code that was most recently finalized by CMS with a lower work RVU than the previous RUC recommended value, the specialty society may

present compelling evidence that that service was based on "flawed methodology" and outline the incorrect methodology (e.g., low survey data point or no specific crosswalk or rationale provided). The Subcommittee also determined that the services with a negative IWPUT would also be considered under the "flawed methodology" compelling evidence standard.

The Subcommittee noted that the process to review any services that specialty societies disagree with the work RVU of an existing code is to submit a letter to CMS as potentially misvalued with a rationale. CMS will nominate any potentially misvalued services in the Notice for Proposed Rule Making (NPRM) and the RUC will examine.

The Subcommittee did not recommend any changes to the compelling evidence standards because the Subcommittee determined that the issues discussed were already included in the current compelling evidence standards.

The full Administrative Subcommittee report is attached to these minutes. The RUC approved the Administrative Subcommittee Report.

XVI. Time and Intensity Workgroup (Tab 33)

Doctor Scott Collins, Workgroup Chair, provided a summary of the Time-Intensity Workgroup report:

- **Post-service Time Package for the Office Setting**

At the October 2016 meeting, the Time-Intensity Workgroup observed that there is currently no standard post-time package for office setting. The Workgroup agreed that a series of post-time packages for the office setting should be considered. Using post-time packages 7A Local Anesthesia/ Straightforward Procedure and 8A Local Anesthesia/ Complex Procedure as a base for the creation of new packages, the Workgroup noted that time for a written post-operative note is not needed in the office setting. Some members questioned if having a minute to transfer a supine patient should be included in the office setting. Also, the Workgroup noted that lines 12 and 13 should be changed to reading Post-operative instructions and prescriptions. Also, the Workgroup noted that there should be a footnote which instructs respondents to add time if general anesthesia is ever typical in the office setting. The Workgroup also questioned whether monitoring patient recovery and stabilization would only apply to moderate sedation. AMA Staff drafted a new time package for the Workgroup to consider at the January meeting. *Note, as the previous suggested changes resulted in two packages with identical times, the mock-up only includes a single package.*

The Workgroup reviewed the below draft post-time package and agreed that they would like to review this draft package further at the April 2017 meeting. The Workgroup requested for AMA staff to perform an analysis to compare current pre-service and post-service times of non-facility procedures to existing packages to attempt to deduce any trends. The Workgroup noted that they liked the draft package in general and plan to forward some version of it to the Research Subcommittee to consider at the Subcommittee's Fall 2017 meeting pending review of planned staff research:

Total Post-Service Time	**14**
Application of Dressing*	2
Transfer of supine patient off table	0
Operative Note	5
Monitor patient recovery/ Stabilization	0
Communication with patient and/or family	5
Written post-operative note	0
Post-Operative Orders and Order Entry	2

- **Discuss Survey Intensity/Complexity Summary Data Addendum**

  As the Subcommittee meeting occurred immediately following the Research Subcommittee meeting, the Workgroup chair provided an overview of the Intensity & Complexity changes recommended by the Subcommittee (as summarized in the Research Subcommittee's January 2017 Report).

- **Scrub, Dress and Wait Intensity**

  At the April 2016 RUC meeting, the American College of Surgeons (ACS) submitted a letter to the RUC concerning the intensity value of 0.0081 that is assigned to the pre-time component "scrub, dress, wait." The ACS noted that they continue to have concerns about the validity of this intensity value in comparison to the intensity of other services. They emphasized that the intent is not to ask for a revaluation of existing RUC work values, but instead is to consider a change in the value of intensity that is used in the IWPUT calculation for the scrub, dress, wait component of pre-service work. The RUC referred this issue to the Time-Intensity Workgroup.

  During the Workgroups discussions at the October 2016 meeting, it was noted that during the Harvard study, the intensity of 0.0081 was derived by expert panel and not from any quantitative analysis. The Workgroup requested for AMA staff to conduct an analyses which looks at variation in scrub/dress/wait (SDW) time across the fee schedule and also which provides the overall scope of how SDW and the other pre-time components impact the fee schedule (included). A letter that ACS submitted to the Research Subcommittee in 2014 with detailed analyses and rationales was also included in the agenda packet for the Workgroup's reference.

  At the January meeting, several Workgroup members reiterated that the Harvard study had assigned the intensity value for scrub dress and wait by expert panel. One Workgroup member suggested for the ACS to considering proposing new ideas for valuing S/D/W, such as conducting a survey to attempt to measure the value of S/D/W time. ACS noted that they appreciated the suggestion and will consider sending a future proposal to either the Workgroup or the Research Subcommittee.

  The Workgroup chair noted that since these values came from the Harvard study, the RUC could only propose an alternate value to CMS and that it would be CMS decision whether to change the intensity value.

  The RUC approved the Time-Intensity Workgroup Report.

XVII. Rotating Seat Elections (Tab 34)

- David C. Han, MD, Society for Vascular Surgery (SVS) was elected to the RUC's Any Other rotating seat.
- Alnoor Malick, MD, American College of Allergy, Asthma & Immunology (ACAAI) was elected to the RUC's Internal Medicine rotating seat.
- The term for the rotating seats is two years, beginning with the April 2017 RUC meeting and ending in January 2019, with the provision of final recommendations to the CMS.

XVIII. Other Business (Tab 35)

- A RUC member raised the issue that while there are now time packages, there are a whole host of services within the fee schedule in which this standard has not been applied. The RUC Member question if there is there a way to use these packages and incorporate them into codes within the schedule that have not been through the RUC process or does the RUC have to wait until the codes come up? **This issue is referred to the Research Subcommittee**
- A RUC member raised the point that pre-service time for surgical services are based on location, type of anesthesia, condition of the patient, and difficulty of the procedure. However, several times during the meeting, the RUC heard that "the survey time was X" and so the reason that it became a difficult patient/difficult procedure is what fit best with the survey. The pre-service time package should be based on the aforementioned factors not the survey time. Doctor Smith agreed that better diligence is needed to ensure that the package applies to the patient. This is a responsibility of the RUC, as it brings the codes through the process. **The RUC referred this issue to the Research Subcommittee to develop definitions for "straightforward patient/straightforward procedure" and "difficult patient/difficult procedure."**
- A RUC member commented that the review of multi-family code tabs might be made easier if there was a summary spreadsheet that only lists the codes and recommended values.
    - Staff indicated that the cover sheets in every tab provide the full context of the recommendation.
- A RUC member requested **that the existing value of the code be added to the top of the SOR** near the proposed RVU. Doctor Smith said the proposed change will be taken into consideration.
- A RUC member recommended that the Administrative Subcommittee review the RUC member participation guidelines as requested by the American College of Surgeons (ACS) and the American Society of Colon and Rectal Surgeons (ASCRS). The representatives were not allowed to participate in the discussion for the Anesthesia for GI Endoscopy codes because they are also members of the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), and SAGES had participated as a level of interest=2, comment only. The specialty societies request further discussion by the Administrative Subcommittee because neither had the authority to speak on behalf of SAGES and there are many RUC members who are members of other societies who are not authorized by those bodies to speak or advocate on their behalf. **The RUC referred this issue to the Administrative Subcommittee for further examination.**

The RUC adjourned at 3:10 p.m. on Saturday, January 14, 2017.

Members Present: Scott Manaker, MD, PhD, (Chair), David C. Han, MD (Vice Chair), Kathy Krol, MD (CPT Resource), Gregory L. Barkley, MD, Eileen Brewer, MD, Joel Brill, MD, Joseph Cleveland, MD, Neal H. Cohen, MD, William Gee, MD, Mollie MacCormack, MD, FAAD, Karla Murphy, MD, Mary Newman, MD, Tye Ouzounian, MD, Stephen Sentovich, MD, Ezequiel Silva, III, MD, W. Bryan Sims, DNP, APRN-BC, FNP, Lloyd S. Smith, DPM, Robert J. Stomel, DO, Thomas Weida, MD, Adam Weinstein, MD

I. Scope Systems and Endoscopes Workgroup

In the Proposed Rule for CY2017, CMS outlined a pricing structure that separated out the components for scopes, scope video systems, and scope accessories. CMS also requested comment on the appropriate endoscopic equipment and supplies for endoscopic procedures. Because of the complexity of the issues CMS raised, and the need to incorporate input from all specialty societies, the RUC submitted comments to CMS that the best approach to this issue is to form a Workgroup and review the Agency's issues. The Scope Systems and Endoscopes Workgroup was formed at the October 2016 RUC meeting and met via conference call on November 2, 2016 to discuss the Centers for Medicare and Medicaid Services (CMS) request for standardization within the description of scope equipment and supplies. In advance of the conference call, AMA staff prepared an analysis of all scope equipment and supplies included in the current direct practice expense inputs. The CMS Final Rule with a proposed structure was released after the conference call and CMS finalized the proposal, without offering to delay pending input from the Workgroup.

During the conference call Steve Phurrough, MD represented CMS explained that as CMS has reviewed codes with scopes over the past few years they noted inconsistency in the methods of determining which equipment is utilized. Prospectively, CMS would like the supply descriptions for endoscopic services to be more specific. The following categories were proposed and finalized by CMS:

<u>Scopes</u>
CMS proposed to identify for each anatomical application: (1) a rigid scope; (2) a semi-rigid scope; (3) a non-video flexible scope; (4) a nonchanneled flexible video scope; and (5) a channeled flexible video scope.

<u>System Used to Operate the Scopes</u>
CMS proposed to include the following components to be included in a scope system – Endoscopy video system equipment item (ES031):

- Monitor
- Processor
- Form of Digital Capture
- Printer
- Cart
- Light

<u>Scope Accessories</u>
These items should continue to be described as justified per each individual procedure

Given that the CMS proposal was finalized in the final rule for 2017 no further action is required of the Workgroup at this time.

II. Standard Equipment Related to Non-Moderate Sedation Post-Procedure Monitoring

The Standard Equipment Related to Non-Moderate Sedation Post-Procedure Monitoring Workgroup met via conference call on October 20, 2016, to discuss post-procedure monitoring that continues to be necessary even as moderate sedation is now a separately billable service. The Workgroup also discussed the issue of the proper allocation of oxygen for services done with moderate sedation. There are a very limited number of services with oxygen as a supply item; however the stand alone moderate sedation codes do not include oxygen in the supplies.

The Workgroup agreed that when a specialty society is able to persuade the PE Subcommittee and RUC that extended monitoring time is required for a code, standardized equipment should be identified. Post-procedure monitoring time following a procedure with sedation has been established to be 60 minutes. Any monitoring time that extends beyond this time would require the continued use of the stretcher only. If the patient is being monitored for an extended period of time to ensure no bleeding, an IV infusion pump and ECG may also be needed.

The Workgroup recommends that prospectively when extended monitoring beyond one hour for a procedure with moderate sedation is necessary; a stretcher (EF018) should be allocated. When extended monitoring beyond the procedure time is necessary due to concerns regarding bleeding; an ECG, 3-channel (with SpO2, NIBP, temp, resp) (EQ011), IV infusion pump (EQ032) and a stretcher (EF018) should be allocated. Additionally all services that include oxygen and the rationale for its maintenance or deletion is included in the table below:

CPT Code	CPT Long Descriptor	Rationale for inclusion of oxygen in procedure code
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	No rationale beyond moderate sedation – delete as duplicative
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	No rationale beyond moderate sedation – delete as duplicative
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	No rationale beyond moderate sedation – delete as duplicative
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])	No rationale beyond moderate sedation – delete as duplicative
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	No rationale beyond moderate sedation – delete as duplicative

31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	No rationale beyond moderate sedation – delete as duplicative
31632	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)	No rationale beyond moderate sedation – delete as duplicative
31633	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)	No rationale beyond moderate sedation – delete as duplicative
31645	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed with therapeutic aspiration of tracheobronchial tree, initial	No rationale beyond moderate sedation – delete as duplicative
31646	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay	No rationale beyond moderate sedation – delete as duplicative
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	No rationale beyond moderate sedation – delete as duplicative
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures	No rationale beyond moderate sedation – delete as duplicative
31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])	No rationale beyond moderate sedation – delete as duplicative
52647	Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)	Specialty – delete oxygen

52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	Specialty – delete oxygen
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	No moderate sedation Related to procedure - Retain
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview)	Specialty - procedure that is rarely done and if done is more likely to be done in an inpatient/ER setting. O2 is needed as a precaution – "if you use too much Amytal, you may suppress respiration and need O2."
90870	Electroconvulsive therapy (includes necessary monitoring)	Rare to be performed in an office setting as the standard of practice is to have an anesthesia provider at hand. Monitoring for ECT, no matter the setting will include EKG, EEG, and pulse oximetry. In addition there is usually a motion sensor which tracks the motor seizure as well as clinical monitoring of motor activity. Treat similar to other codes that would be rarely performed in the office and if performed, require anesthesia. Remove the oxygen and IV infusion set. Anesthesia expense issue to be handled globally with CPT discussion of separate code.
92950	Cardiopulmonary resuscitation (eg, in cardiac arrest)	No moderate sedation Related to procedure - Retain
94453	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration	No moderate sedation Related to procedure - Retain
94726	Plethysmography for determination of lung volumes and, when performed, airway resistance	No moderate sedation Related to procedure - Retain

94727	Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes	No moderate sedation Related to procedure - Retain
94750	Pulmonary compliance study (eg, plethysmography, volume and pressure measurements)	No moderate sedation Related to procedure - Retain
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	No moderate sedation Related to procedure - Retain
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)	No moderate sedation Related to procedure - Retain
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval	No moderate sedation Related to procedure - Retain

III. Practice Expense Recommendations for CPT 2018

Tab	Title	PE Input Changes
4	Anesthesia for GI Procedures	No Change
5	Muscle Flap	Modifications
6	Bone Marrow Aspiration	No PE Inputs
7	Nasal-Sinus Endoscopy	Modifications
8	Cryoablation of Pulmonary Tumors	Modifications
9	Artificial Heart System Procedures	No PE Inputs
10	Endovascular Repair Procedures (EVAR)	No Change
11	Treatment of Incompetent Veins	Minor Modifications
12	Therapeutic Apheresis	Modifications

Tab	Title	PE Input Changes
13	Peri-Prostatic Implantation of Biodegradable Material	Modifications
14	Colporrhaphy with Cystourethroscopy	No Change
15	Percutaneous Neurostimulator Placement	Minor Modifications
16	Nerve Repair with Nerve Allograft	Minor Modifications
17	Photodynamic Therapy	Modifications
18	Psychological and Neuropsychological Testing	Refer to CPT
19	INR Monitoring	Modifications
20	Psychiatric Collaborative Care Management Services	Minor Modifications
21	CT Soft Tissue Neck	No Change
22	Ultrasound of Extremity	Minor Modifications
23	Cardiac Electrophysiology Device Monitoring Services	Affirm October 2016 PE Inputs
24	Intracardiac 3D Mapping add-on	No PE Inputs
25	IV Hydration	Modifications
26	Application of On-body Injector with Subcutaneous Injection	Modifications
27	Chemotherapy Administration	Modifications

Tab	Title	PE Input Changes
29	Cognitive Function Intervention	Modifications
	Psychological and Neuropsychological Testing	Refer to CPT
	Physical Medicine and Rehabilitation Services	Modifications
	Orthotic Management and Prosthetic Training	Modifications
	Application of Surface Neurostimulator	Refer to CPT

Members Present

Chair:	
Michael Bishop, MD	AMA/Specialty Society RVS Update Committee
Co-Chair:	
Jane White, PhD, RD, FADA	Academy of Nutrition and Dietetics (AND)
Alt. Co-Chair:	
Dee Adams Nikjeh, PhD, CCC-SLP	American Speech-Language-Hearing Association (ASHA), Speech Language Pathology
Members:	
Margie Andreae, MD	AMA/Specialty Society RVS Update Committee
Leisha Eiten, AuD	American Speech-Language-Hearing Association (ASHA), Audiology
Charles Fitzpatrick, OD	American Optometric Association (AOA)
Anthony Hamm, DC	American Chiropractic Association (ACA)
Peter Hollmann, MD	AMA/Specialty Society RVS Update Committee
Katie Jordan, OTD, OTR/L	American Occupational Therapy Association (AOTA)
Randy Phelps, PhD	American Psychological Association (APA)
Richard Rausch, PT	American Physical Therapy Association (APTA)
W. Bryan Sims, DNP, APRN-BC, FNP	American Nurses Association (ANA)
Timothy Tillo, DPM	American Podiatric Medical Association (APMA)
Doris Tomer, LCSW	National Association of Social Workers (NASW)

Introductions and CMS Update

Edith Hambrick, MD, JD, MPH noted the nominations of Tom Price, MD for Health and Human Services Secretary and Seema Verma, MPH as the Administrator of the Centers for Medicare and Medicaid Services (CMS). She informed the committee that no further changes in career staff are known at this time. Doctor Hambrick encouraged organizations to meet with CMS soon if they have items for consideration for the Proposed Rule.

HCPAC Elections

The HCPAC expressed appreciation to Jane White, PhD, RD for her service as she retires from the HCPAC.

Dee Adams Nikjeh, PhD, CCP-SLP was elected Co-Chair of the HCPAC Review Board.

Timothy Tillo, DPM was elected alternate Co-Chair of the RUC HCPAC Review Board.

Recommendations

Cognitive Function Intervention (97X11)
American Speech-Language-Hearing Association
American Psychological Association

97X11 *Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks, direct (one-on-one) patient contact* replaces former code 97532 (2017 work rvu = 0.44), a service that was reported in increments of 15 minutes and typically reported with 4 units of service. The Review Board determined that

97X11 (pre=5/intra=60/post=10) was most comparable to CPT code 92522 *Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)* (work rvu=1.50, pre=5/intra=60/post=20). The HCPAC recommends 1.50 for 97X11).

The Review Board approved the practice expense inputs as proposed by the PE Subcommittee.

Psychological and Neuropsychological Testing (RUC - 96110, 96116, 963X1-2, 963X4, 963X6, 96127; HCPAC – 96105, 96125, 963X0, 963X3, 963X5)
American Speech-Language-Hearing Association (96105, 96125)
American Psychological Association (963X0, 963X3, 963X5)

The HCPAC Review Board supports the recommendation to refer this issue back to the CPT Editorial Panel. It is understood that the issue will be addressed in the CPT 2019 cycle.

Physical Medicine and Rehabilitation Services (97010-97542)
American Physical Therapy Association
American Occupational Therapy Association

CPT Code	Descriptor	Work RVU	Pre-Time	Intra-Time	Post-Time	Rationale/Discussion
97010	Application of a modality to 1 or more areas; hot or cold packs					Refer to CPT Code is currently bundled by CMS
97012	Application of a modality to 1 or more areas; traction, mechanical	0.25	1	10	1	Current value Non-attended modality should include a note in database that the code should not be used for future comparisons
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	0.18	1	7	1	Current value Non-attended modality should include a note in database that the code should not be used for future comparisons
97016	Application of a modality to 1 or more areas; vasopneumatic devices	0.18	1	8	1	Current value Non-attended modality should include a note in database that the code should not be used for future comparisons
97018	Application of a modality to 1 or more areas; paraffin bath	0.06	1	8	1	Current value Non-attended modality should include a note in database that the code should not be used for future comparisons

97022	Application of a modality to 1 or more areas; whirlpool	0.17	1	12	1	Current value Non-attended modality should include a note in database that the code should not be used for future comparisons
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	0.25	1	15	2	Current value
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	0.26	1	12	2	Current value
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes	0.21	1	15	2	Current value
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	0.21	1	10	2	Current value
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	0.45	2	15	2	25th percentile and Current value
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	0.50	2	15	2	**Compelling Evidence Approved** Patents are referred to PT earlier and are therefore more acute. Patient expectation has increased. Knowledge and technology has increased. 25th percentile
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	0.48	2	15	2	**Compelling Evidence Approved** Patents are referred to PT earlier and are therefore more acute. Patient expectation has increased. Knowledge and technology has increased. Risk of falls and water safety make the service more intense. 25th percentile

97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	0,45	2	15	2	**Compelling Evidence Approved** Patents are referred to PT earlier and are therefore more acute. Patient expectation has increased. Knowledge and technology has increased. Crosswalk to 93016 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report* (work rvu = 0.45; pre=2/intra=15/post=2) Also same work as 97110
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	0.43	2	15	2	25th percentile and Current value
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	0.44	2	15	2	Current value
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	0.48	3	15	5	**Compelling Evidence Approved** Typical patient is a child and children are identified and referred for therapy at a younger age. 2 units of service is typical – total time of 6 pre and 10 post reasonable and divided by two for valuation of individual code. 25th percentile
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	0.45	2.5	15	4	Current value Typical patient is non-Medicare and receives two units of service.

97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes	0.48	5	15	5	**Compelling Evidence Approved** Patient population has changed Typical patient is non-Medicare and receives two units of service. 25th percentile
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	0.48	3	15	5	**Compelling Evidence Approved** Equipment dramatically changed 25th percentile
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	0.18	1	7	1	CMS originally valued to be same as 97014. This relationship is correct. G0283 should be crosswalked to 97014 for work and time. Current Value

The Review Board approved the practice expense inputs as proposed by the PE Subcommittee. Equipment time should be reviewed to ensure revisions to therapist time considered.

Orthotic Management and Prosthetic Training (97760-61, 977X1)
American Physical Therapy Association
American Occupational Therapy Association (97760 & 977X1)

CPT Code	Descriptor	Work RVU	Pre-Time	Intra-Time	Post-Time	Rationale/Discussion
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	0.50	5	15	5	**Compelling Evidence Approved** New technology and customization 25th percentile
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	0.50	5	15	5	**Compelling Evidence Approved** New technology and increased patient expectation 25th percentile

977X1	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/ prosthetic(s) encounter, each 15 minutes	0.48	2.5	15	5	**Compelling Evidence Approved** New technology and acuity of patients seen sooner 25th percentile Comparable to 97116 *Gait training* (work rec rvu=0.48)

The Review Board approved the practice expense inputs as proposed by the PE Subcommittee.

Application of surface neurostimulator (64550)
American Occupational Therapy Association

The HCPAC Review Board supports the recommendation to refer this issue back to the CPT Editorial Panel. It is understood that the issue will be addressed in the CPT 2019 cycle.

Members: Doctors David Hitzeman (Chair), Gregory Przybylski (Vice-Chair), Ronald Burd, Jimmy Clark, William Donovan, Gwenn Jackson, Timothy Laing, Walt Larimore, Daniel Nagle, Guy Orangio, Marc Raphaelson, Samuel Silver, Michael Sutherland, George Williams and Robert Zwolak.

I. Flagged Services - Action Plan Review (57155 & 57156)

Insertion of Uterine Tandem/Ovoids (57155 and 57156)

These services were identified in September 2007 via the Site-of-Service Anomaly screen. The specialty societies indicated that the typical patient for 57155 may have changed requiring modification to the descriptor. In October 2009, the CPT Editorial Panel added a new code to report the insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy and revision of 57155 to indicate insertion of a single tandem rather than tandems. In October 2013, AMA staff reviewed the work neutrality impacts for codes reviewed in the CPT 2011 cycle. Work neutrality was appropriately maintained. However, there was one issue where there was a large growth in utilization in the first year for new CPT code 57156. The specialty societies predicted that with the creation of new CPT code 57156, the utilization would be split 50/50 for 57155 and 57156. However, the utilization split was 37/63 for 2011 and 29/71 for 2012. CPT code 57155 originally described multiple tandems and was changed to describe one tandem. The Workgroup reviewed the action plan in which the specialty society indicated that the utilization is appropriate and the split between the two codes is consistent with the current clinical trends. The specialties indicated that there has been a decrease in the incidence of cervical cancer, typically treated with CPT 57155, but there has been an increase in the incidence of endometrial cancer typically treated with CPT 57156. The Workgroup determined it will reassess these services after more data is available. The Workgroup recommended another review of claims data for 57155 and 57156 in 3 years (October 2016).

At the October 2016 Workgroup meeting, the societies indicated that the current estimated RVU split of 35%/65% is consistent with the current clinical trends and supported by consistent Medicare (RUC database) trends. When the Workgroup reviewed this issue the final recommendation to survey this issue was based on an incorrect data point. The specialty society noted that in 2011 the RUC recommendation was not accepted and the 2011 interim final recommendation was lower. Work neutrality was maintained and the split continues to be lower for the higher valued code. The specialty society requested and the Workgroup agreed, that this issue be discussed at the January 2017 RAW meeting to clarify and allow the Workgroup to review the correct data.

After correcting the 2011 interim final work RVUs the split of these services are as indicated below. **The Workgroup determined that codes 57155 and 57156 being reported appropriately and to remove from further review under this work neutrality examination.**

CPT Code	2012 Long Descriptor	2011 Interim Final work RVU	2012 Final Work RVU	2011 Split	2012 Split	2013 Split	2014 Split	2015 Split
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	3.37	5.40	51%	45%	39%	38%	35%
57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	1.87	2.69	49%	55%	61%	62%	65%

II. Codes Reported Together – Action Plan Review (22558 & 63090)

Vertebral Corpectomy (22558 & 63090)

In January 2015, the Joint CPT/RUC Workgroup recommended a bundling solution for codes 22558 and 63090. The specialty societies have reviewed CPT coding guidelines and educational materials for 63090 and believe 63090 may have been inappropriately reported with 22558 because there is no definition for partial vertebral corpectomy in CPT. In September 2016, the CPT Editorial Panel added introductory language to the guidelines defining partial vertebral corpectomy. The 2014 Medicare data indicate that 22558 and 63090 are reported together 72% of the time.

In January 2017, the Relativity Assessment Workgroup reviewed the action plan addressing whether a bundling solution is still necessary or if the education and coding guideline changes address this issue. The specialty societies indicated that the utilization for 63090 should decrease significantly after the CPT 2018 changes and should be reviewed after additional data is available. **The Workgroup agreed that codes 22558 & 63090 reported together are decreasing and recommend that the Workgroup review the reported together data after the 2018 changes are in effect and two years of data are available (October 2022).**

III. High Volume Codes – Action Plan Review (11 codes)

AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2009 through 2014. The query resulted in the identification of 11 services. **The Relativity Assessment Workgroup reviewed the action plans submitted by the specialty societies and recommends.**

CPT Code	Recommendation
00537	Review additional utilization data in two years (October 2019). Notify the Anesthesia Workgroup that this is a high growth service.
01936	Request that the specialty society research data on what procedures are reported with this anesthesia code. Review action plan in April 2017.
31623	Survey October 2017.
64450	Request the specialty societies review this issue further to determine if there are any other peripheral nerves or branches not specified with a CPT code to determine if this service may be deleted. Review action plan April 2017.
64455	Currently on LOI to survey for April 2017 as identified by CMS in the 000-day global service typically reported with an E/M screen.
77435	Remove from screen. This service has been consistently reviewed by the RUC and PE Subcommittee since their creation (2011) and the growth remains modest.
77523	This service is carrier priced and determined appropriate. Remove from screen.
78492	Refer to CPT Editorial Panel to undergo substantive descriptor changes to reflect newer technology aspects such as wall motion, ejection fraction, flow reserve, and technology updates for hardware and software. CPT 2019 cycle.
93571	Survey October 2017.
95951	Refer to CPT Editorial Panel June 2017/RUC Oct 2017 for needed changes, including code deletions, revision of code descriptors, and the addition of new codes to this family. Revisions to this family of codes are needed to recognize that video is now an element of most long term EEG monitoring tests and to better differentiate inpatient and ambulatory monitoring services.

G0102	Remove from screen. This is a federally mandated carve-out service of the exam that is otherwise included in preventive medicine CPT codes such as 99397.

IV. Final Rule – 000-Day Global Services Reported with an E/M with Modifier 25

In the NPRM for 2017 CMS identified 83 services with a 000-day global period billed with an E/M 50 percent of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000.

The RUC commented that it appreciated CMS' identification of an objective screen and reasonable query. However, based on further analysis of the codes identified, it appears only 19 services met the criteria for this screen and have not been reviewed to specifically address an E/M performed on the same date. There were 38 codes that did not meet the screen criteria; they were either reviewed in the last 5 years and/or are not typically reported with an E/M. For 26 codes, the summary of recommendation (SOR), RUC rationale or practice expense inputs submitted specifically states that an E/M is typically reported with these services and the RUC accounted for this in its valuation.

The RUC requested that CMS remove 64 services that did not meet the screen criteria or which have already been valued as typically being reported with an E/M service. The RUC requested that CMS condense and finalize the list of services for this screen to the 19 remaining services.

In the Final Rule for 2017, CMS did finalize the list of 000-day global services reported with an E/M to the 19 services that truly met the criteria. The 19 services CMS identified that have not been reviewed as typically being reported with an E/M service will be placed on the next Level of Interest (LOI) form for survey and presentation at the April 2017 RUC meeting.

In January 2017, AAOS, ASSH and APMA noticed that the RUC database did not have the vignette shown for CPT code 20612, but instead the intra-service work was inserted in the vignette cell. Upon review of the summary of recommendation for 20612 that was presented at the April 2002 meeting, the specialty societies discovered that in fact an E/M as typical was considered in the survey process; the survey vignette had a "note" directing the survey respondents to NOT include E/M work when completing the survey. **The specialty societies recommend and the Workgroup agrees that CPT code 20612 should be removed from this screen the valuation of this service already excludes any E/M with this service. The Workgroup recommends that CMS remove 20612 from this screen and the RUC database be revised to include the correct vignette for codes 20612 and 20526.**

V. Joint CPT/RUC Codes Reported Together Frequently Workgroup Report

Doctor Krol presented the Joint Workgroup report and indicated that the Workgroup reviewed four specific code bundle possibilities and determined that the reporting together of these services have already been addressed or a code bundle solution is not necessary. The full Joint CPT/RUC Codes Reported Together Frequently Workgroup report is attached to this report.

VI. Informational Items

The following documents were filed as informational items: Referrals to the CPT Editorial Panel; Potentially Misvalued Services Progress Report and CMS/Relativity Assessment Status Report.

Joint CPT/RUC Workgroup on Codes Reported Together
Teleconference Report
December 6, 2016

Members Present: Doctors Mark Synovec (Chair), Kathy Krol, Walter Larimore, Dee Adams Nikjeh, Bernard Pfeifer, Zeke Silva and Robert Zwolak

I. Group 1 – Radiotherapy planning with treatment devices 77295/77334; 77301/77338; 77333/77290

American Society for Radiation Oncology (ASTRO)

The Workgroup reviewed the action plans for these code pairs. The codes identified in this screen have been recently RUC surveyed/reviewed. The specialties indicated that when these codes were surveyed and presented the specialty was mindful of billed together codes. At that time, the specialty presented and the RUC discussed the code sets identified in this CPT/RUC billed together review. The RUC did not specify the code pairs typically performed together in each rationale. However, the summary of recommendation forms submitted with the recommendations to CMS, all confirm that the RUC considered these specific code pairs and confirmed there was no overlap in physician work or direct practice expenses.

The specialty society also noted that the code sets identified by this screen represent various PC/TC/Global combinations. The radiation planning/simulation/device codes are all PC/TC codes which allow the physician to report only the work performed. A bundled CPT solution would preclude the physician from reporting only the aspects of the services performed. The Workgroup agreed that creating bundled codes would be difficult since many combinations would need to be described and would cause confusion. The Workgroup agreed that the current coding structure allows the physician to report only the work performed and is appropriate.

The Workgroup recommends that the RUC add to the rationale in the RUC database that these code families (77280, 77285, 77290, 77293, 77295, 77300, 77301, 77332, 77333, 77334 and 77338) were considered along with the typical codes with which they are reported with and any duplication in physician work and direct practice expense inputs was considered and addressed.

The Workgroup recommends that removing these code pairs from this screen as there is no duplication of work or direct practice expenses therefore bundled codes are not necessary.

II. Group 2 – Cytopathology with Interpretation & report/flow cytometry with additional markers - 88172/88173 and 88182/88189

College of American Pathologists (CAP)

The Workgroup agreed with the specialty society that there is no duplication in physician work or direct practice expenses for the 88172/88173 codes reported together. The RUC considered and eliminated any duplication as it recognized these codes may be reported together, when the RUC reviewed in April 2010. CPT code 88172 does not have physician pre- or post-service time and the direct practice expense medical supplies such as microscope slides and stains are not included. The specialty society also noted an issue with the screen parameters as it pertains to pathology services whereby the assigned date of service by Medicate rules is the date of specimen acquisition, not the actual date that the service is performed by the physician. **The Workgroup recommends removing code pair 88172/88173 from this screen as there is no duplication of work or direct practice expenses; therefore, a bundled code is not necessary.**

The Workgroup reviewed 88182/88189 code pair and agreed with the specialty society that this code pair should not have appeared on this screen. The Workgroup previously established a standard to remove all codes that are below 1,000 Medicare claims and/or contain at least one ZZZ global service. The specialty society noted that the actual global utilization for 88182 in was 502 and should have been eliminated from the screen. The Workgroup noted that the current 2015 total Medicare utilization of 5,200 is the global plus professional component (-26) volume and that the PC comprises most of the volume with 4,698 leaving the global Medicare utilization for CPT code 88182 at 502. **The Workgroup agreed that this did not meet the established criteria for this screen and recommends removing code pair 88182/88189.**

III. Group 3 - Arthrodesis/Arthroplasty with Other Surgical Procedures 25310/25447 and 26480/25447

American Society for Surgery of the Hand (ASSH)
American Academy of Orthopaedic Surgeons (AAOS)

The Workgroup reviewed the action plan from the specialty societies and agreed that: 1) When performed with 25447, codes 25310 and 26480 are performed through a separate incision and the 50% multiple procedure reduction correctly accounts for overlapping pre and postoperative work; 2) Code 25310 is reported only 32% of the time with 25447 and code 26480 is billed only 37% of the time with 25447 for Medicare age patients; and 3) Codes 25310 and 26480 are not typically performed in the Medicare-aged population, but instead are more often reported for hand trauma. If there were data available for all patients, these code pairs would have a very low billed-with percentage.

The Workgroup determined the frequency of these services being performed together is low and any duplication is address by the MPPR. Therefore, bundled codes are not necessary. The Workgroup recommends removing codes 25310/25447 and 26480/25447 from the codes reported together screen.

IV. Group 4 - Aqueous Shunt with Scleral Enforcement 66180/67255

American Academy of Ophthalmology (AAO)

The Workgroup reviewed the action plan and determined that the data gathered for this screen was based on 2014 Medicare data and "reported together" issues between these two codes were resolved in 2015. This family was recently revised and reviewed by the RUC in 2015. CPT 66180 and 67255 cannot be billed together based on the 2015 revisions. The CPT book states the following parenthetical: "(Do not report CPT 66180 in conjunction with CPT 67255)". Additionally, the descriptor for CPT code 66180 was revised in to indicate that 66180 is the service that should be used if a graft is included with a glaucoma shunt procedure. Further, the work descriptor for 66180 was updated to describe inclusion of the graft. The new work value that went into effect in 2015 includes the work of applying the graft over the shunt when performed and the two codes can no longer be billed together.

The Workgroup recommends that CPT codes 66180 and 67255 be removed from this screen as the issue has been addressed.

AMA/Specialty Society RVS Update Committee **Tab 31**
Research Subcommittee
January 12, 2017

Members: M. Douglas Leahy, MD (Chair), Christopher Senkowski, MD (Vice Chair), Margie Andreae, MD, Allan Anderson, MD, Amy Aronsky, DO, James Blankenship, MD, Robert Dale Blasier, MD, Kathleen Cain, MD, Scott Collins, MD, Verdi DiSesa, MD, Jeffrey Edelstein, MD, Peter Hollmann, MD, Alan Lazaroff, MD, Stanley W. Stead, MD, MBA, G. Edward Vates, MD, Jane White, PhD, RD, Jennifer Wiler, MD, MBA

I. Research Subcommittee October 18, 2016 Conference Call Meeting Report

The Research Subcommittee report from the October 2016 conference call included in Tab 31 of the January 2017 agenda materials was approved without modification.

II. RUC Survey Physician Time Question – Precision of physician time data

At the December 2015 Time-Intensity Workgroup meeting, as part of a discussion on measuring physician time, several Workgroup members noted that survey results often appear that the survey respondents tend to round to the nearest 5 minute or 15 minute increment instead of providing estimates to the nearest minute. The Research Subcommittee discussed this issue at its April 2016 meeting. At that time, several Research Subcommittee members noted that language requesting for the survey respondent "not to round" and/or to be "as precise as possible" should be incorporated in the proposed text. Following discussion, the Subcommittee referred this issue to the Time-Intensity Workgroup for further discussion.

At the October meeting, the Time-Intensity Workgroup discussed this issue in detail. Following the discussion of several ideas, the Workgroup agreed that the language should not be too complicated or provide any restrictive guidance. One Workgroup member suggested the custom language that the Research Subcommittee had previously approved for the survey template for tab 13 Strapping Multi-Layer Compression, with minor modification, which is listed below.

The Time-Intensity Workgroup recommended for the question text to be modified as follows:

> **Question 2 (from RUC Online Survey Tool):** How much of your own time is required per patient treated for each of the following steps in patient care related to this procedure? **It is important to be as precise as possible. For example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes.** *Indicate your time for the survey code(s) (in minutes) in each box below. If you do zero minutes for one of the below time components, then you would need to put 0.*
>
> *Please refer to the information above for a list of definitions.*

The Research Subcommittee discussed the above modified language and agreed that the proposed language may potentially result in more specificity of survey time data. **The Research Subcommittee approved for the new language to be added to all standard RUC survey templates.** The Subcommittee also requested for AMA staff to conduct an analysis once possible to attempt to determine whether the change has had any impact.

III. Requirement to Present Summary Data to RUC if Survey is Conducted

In 2014, a RUC member brought up a concern regarding the current ability for specialty societies to conduct a survey and then request to resurvey, without ever having to submit a summary of the original survey data to the RUC. The RUC member proposed that if a survey is conducted, then a summary of the original data would need

to be submitted to the RUC. This issue was referred to the Research Subcommittee and discussed at the September 2014 meeting. The Research Subcommittee did not recommend the adoption of the proposal at that time. Instead, the Subcommittee requested for AMA staff to track the occurrences and will re-evaluate the issue in two years, at the October 2016 meeting.

For 2015-2016, there have been 6 additional issues where surveys were conducted and the summary data was not provided. In addition to currently not being required to provide summary data, societies are also not required to disclose whether they conducted a survey when requesting a delay, so there may be additional tabs that also did not share summary data. During the October meeting discussion, some Subcommittee members noted their discomfort with the ability for societies to decide to resurvey without having to provide a detailed explanation of their rationale or having to provide their current summary data. Other Subcommittee members noted that there was no apparent pattern of societies regularly requesting resurvey without providing data.
AMA staff noted that in addition to the table showing the history of how often societies requested resurvey without providing a summary of their original data, there were a similar number of instances where societies requested resurvey but did provide summary data. The Research Subcommittee decided to table this issue for the January 2017 meeting and for AMA staff to provide historical information which also showed when societies requested resurvey but also provided the summary data.

At the January 2017 meeting, the Subcommittee reviewed the updated information provided by staff and noted that this seems to be a relatively uncommon issue and that there does not seem to be any pattern. Several Subcommittee members noted that the most common rationale was due to societies referring codes to CPT after discovering something after launching their surveys. The Subcommitee agreed that no rule was needed at this time and also noted that they could revisit the issue in two years to continue to track this issue.

IV. Review of Suggestion from Time-Intensity Workgroup regarding Survey Intensity and Complexity Questions

As part of its discussion of the intensity and complexity measures, the Time-Intensity Workgroup observed that in addition to the overall intensity question, there are currently 8 other component questions which seems too granular. Several Workgroup members noted their belief that the intensity and complexity questions should be collapsed into fewer questions. One Workgroup member suggested that the 3 Mental Effort and Judgment questions and the 3 psychological stress questions should each be collapsed into a single question, respectively. Several Workgroup members noted their belief that this would help improve survey response rates while also providing a sufficient amount of data for the RUC to review. The Time-Intensity Workgroup recommended for the Research Subcommittee to consider only having 5 total intensity and complexity questions: Mental Effort and Judgment, Technical Skill, Physical Effort, Psychological stress and Overall intensity. Also, the Workgroup recommends for the definitions for each component of intensity and complexity to remain unchanged.

The Research Subcommittee approved the Time-Intensity Workgroup's recommendation, to collapse the 3 mental effort and judgment and 3 psychological stress intensity and complexity questions each into a single question. The Subcommittee requested for AMA Staff to draft updated survey language for its consideration at the April 2017 RUC meeting.

Separately, a Subcommittee member also proposed for the Subcommittee to consider replacing the old Intensity and complexity summary ratings in the Summary of Recommendations form with the new Intensity and Complexity percent distribution measures (currently included in the "Intensity & Complexity Addendum"). Another Subcommittee member noted that an AMA Economist who attended the Time-Intensity Workgroup session at the October 2016 meeting had noted that certain aspects of the old summary data methodology was not appropriate (ie assigning text answers arbitrary numeric values and then averaging those values). **The Subcommittee approved for the new Time-Intensity Measures to be incorporated into the Summary of Recommendation form, replacing the old measures:**

Top Ref Code:		**# of Respondents:**		**% of Respondents:**	
Top Ref Code Descriptor:					

		Survey Code Compared to Top Ref Code				
Overall Intensity and Complexity:		**Survey Code is:**				
		Much Less	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Mental Effort and Judgment:	**The number of possible diagnosis and/or number of management options that must be considered**	**Less**		**Identical**		**More**
	The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	**Less**		**Identical**		**More**
	Urgency of medical decision making	**Less**		**Identical**		**More**
Technical Skill:		**Less**		**Identical**		**More**
Physical Effort:		**Less**		**Identical**		**More**
Psychological Stress:	**The risk of significant complications, morbidity and/or mortality**	**Less**		**Identical**		**More**
	Outcome depends on the skill and judgment of physician	**Less**		**Identical**		**More**
	Estimated risk of malpractice suite with poor outcome	**Less**		**Identical**		**More**

A Research Subcommittee member also proposed a new idea where perhaps the intensity and complexity summary data should only be included in the SOR if at least a certain percentage of respondents had selected the top key reference code. The Subcommittee referred this idea to the Time-Intensity Workgroup for future discussion.

V. Request to conduct Proctored Survey during Society's Annual Meeting for Biopsy of Skin Lesion
American Academy of Dermatology Association

The American Academy of Dermatology Association requested to perform a proctored survey for new biopsy of skin lesion codes for the April 2017 RUC meeting. This survey would take place during the Specialty's Annual meeting in March. AMA Staff noted that an AMA staff representative and a RUC member would both need to be present to observe a proctored survey. Several Subcommittee members expressed concern about the logistics and other potential hurdles for conducting a proctored survey. The Subcommittee did not approve a proctored survey for these services.

AMA/Specialty Society RVS Update Committee **Tab 32**
Administrative Subcommittee
January 12, 2017

Members: Doctors James Waldorf (Chair), Holly Stanley (Vice Chair), Amr Abouleish, Michael Bishop, Gregory DeMeo, William Fox, John Lanza, Swati Mehrotra, Eileen Moynihan, Julia Pillsbury, Eugene Sherman and Norman Smith.

I. Review Rotating Seat Candidates Nominated (Tab 34)

The Administrative Subcommittee reviewed the nominations for the "Any Other" rotating seat, David C. Han, MD, Society for Vascular Surgery and the internal medicine rotating seat, noting that the sole candidate had withdrawn and additional nominations will be due by Friday, January 13th (note: two individuals were nominated by Friday, January 13th). The Subcommittee noted that "an election will be unnecessary in the case that there is an unchallenged seat and the seat will be awarded to the candidate by voice vote."

II. Review Primary Care Rotating Seat Eligibility Criteria

The primary care rotating seat eligibility criteria requires documentation confirming candidates are defined as a primary care physician by Medicare or Medicaid. Documentation of one's primary care bonus eligibility was required. The Medicare primary care bonus ended in 2015 and can no longer be used to confirm primary care Medicare status.

In October 2016, the Administrative Subcommittee reviewed the eligibility criteria and recommended revisions. After extensive discussion, the RUC determined that additional edits were necessary and postponed this issue until the January 2017 meeting to discuss further.

The Administrative Subcommittee reviewed the Primary Care Rotating seat eligibility criteria and noted that the RUC's primary care rotating seat determination is based on the qualifications of the individual candidates nominated, not the specific appointing specialty society. **The Workgroup recommends the revised Primary Care rotating seat candidate eligibility requirement as follows:**

> Candidate Eligibility
>
> The RUC approved that subspecialties deemed eligible for the Internal Medicine or other rotating seats, may choose individuals that represent the interest of the subspecialty group and that a board certification in that particular specialty is not a requirement.
>
> The Primary Care rotating seat candidate must be in active clinical practice, with at least 50% of their professional time in direct patient care. The Primary Care rotating seat candidate must present documentation that he/she is defined as a primary care physician by Medicare or Medicaid and the candidates' evaluation and management services (excluding hospital inpatient care and emergency department visits) account for at least 60 percent of the practitioners total allowed charges under the physician fee schedule. The Primary Care rotating seat candidate must be a physician with significant experience and expertise in broad-based chronic disease management, comprehensive treatment plan development and management, and preventive care.

III. Review RUC Compelling Evidence Standards

In April 2016, A RUC member requested review of the compelling evidence standards regarding the definition and rules. The RUC member noted that when reviewing these standards, the Administrative Subcommittee should consider that in cases when a code is resurveyed and CMS did not accept previous recommended RUC value, compelling evidence based on flawed mechanism (CMS unilateral decision) can be used to recommend a value that is equal to the previous RUC recommended value, but additional compelling evidence would need to be presented if recommended value is higher than the previous recommended value.

In October 2016, the Subcommittee did not have time to address multiple items regarding adding compelling evidence standards for instances when CMS rejected a RUC recommended work RVU and a specialty society is coming back to the RUC with a higher work RVU than the CMS accepted value. The Subcommittee determined that it would discuss the addition of this language to the RUC Rules Regarding Presentation and Evaluation of Work Relative Values Compelling Evidence standards, as well as discuss adding other compelling evidence standards such as negative IWPUT at the January 2017 Administrative Subcommittee.

In January 2017, the Subcommittee determined that the existing "flawed mechanism or methodology" compelling evidence standard bullet already includes circumstances when a specialty society returns to the RUC with a recommendation that is the same as a RUC recommended value for a code in which CMS finalized lower than the RUC recommended value. Therefore, if a specialty society is presenting a code that was most recently finalized by CMS with a lower work RVU than the previous RUC recommended value, the specialty society may present compelling evidence that that service was based on "flawed methodology" and outline the incorrect methodology (e.g., low survey data point or no specific crosswalk or rationale provided). The Subcommittee also determined that the services with a negative IWPUT would also be considered under the "flawed methodology" compelling evidence standard.

The Subcommittee noted that the process to review any services that specialty societies disagree with the work RVU of an existing code is to submit a letter to CMS as potentially misvalued with a rationale. CMS will nominate any potentially misvalued services in the Notice for Proposed Rule Making (NPRM) and the RUC will examine.

The Subcommittee did not recommend any changes to the compelling evidence standards.

AMA/Specialty Society RVS Update Committee **Tab 33**
Time-Intensity Workgroup
January 12, 2017

Members: Scott Collins, MD (Chair), Stan Stead, MD (Vice Chair), Gregory L. Barkley, MD, Michael Bishop, MD, James Blankenship, MD, Eileen Brewer, MD, Ronald Burd, MD, Joseph Cleveland, MD, Alan Lazaroff, MD, Charles Mabry, MD, Scott Oates, MD, Randy Phelps, PhD, Richard Rausch, PT, Robert Stomel, DO

I. Post-service Time Package for the Office Setting

At the October 2016 meeting, the Time-Intensity Workgroup observed that there is currently no standard post-time package for office setting. The Workgroup agreed that a series of post-time packages for the office setting should be considered. Using post-time packages 7A Local Anesthesia/ Straightforward Procedure and 8A Local Anesthesia/ Complex Procedure as a base for the creation of new packages, the Workgroup noted that time for a written post-operative note is not needed in the office setting. Some members questioned if having a minute to transfer a supine patient should be included in the office setting. Also, the Workgroup noted that lines 12 and 13 should be changed to reading Post-operative instructions and prescriptions. Also, the Workgroup noted that there should be a footnote which instructs respondents to add time if general anesthesia is ever typical in the office setting. The Workgroup also questioned whether monitoring patient recovery and stabilization would only apply to moderate sedation. AMA Staff drafted a new time package for the Workgroup to consider at the January meeting. *Note, as the previous suggested changes resulted in two packages with identical times, the mock-up only includes a single package.*

The Workgroup reviewed the below draft post-time package and agreed that they would like to review this draft package further at the April 2017 meeting. The Workgroup requested for AMA staff to perform an analysis to compare current pre-service and post-service times of non-facility procedures to existing packages to attempt to deduce any trends. The Workgroup noted that they liked the draft package in general and plan to forward some version of it to the Research Subcommittee to consider at the Subcommittee's Fall 2017 meeting pending review of planned staff research:

Total Post-Service Time	**14**
Application of Dressing*	2
Transfer of supine patient off table	0
Operative Note	5
Monitor patient recovery/ Stabilization	0
Communication with patient and/or family	5
Written post-operative note	0
Post-Operative Orders and Order Entry	2

II. Discuss Survey Intensity/Complexity Summary Data Addendum

As the Subcommittee meeting occurred immediately following the Research Subcommittee meeting, the Workgroup chair provided an overview of the Intensity & Complexity changes recommended by the Subcommitteee (as summarized in the Research Subcommittee's January 2017 Report).

III. Scrub, Dress and Wait Intensity

At the April 2016 RUC meeting, the American College of Surgeons (ACS) submitted a letter to the RUC concerning the intensity value of 0.0081 that is assigned to the pre-time component "scrub, dress, wait." The ACS noted that they continue to have concerns about the validity of this intensity value in comparison to the intensity of other services. They emphasized that the intent is not to ask for a revaluation of existing RUC work values, but instead is to consider a change in the value of intensity that is used in the IWPUT calculation for the scrub, dress, wait component of pre-service work. The RUC referred this issue to the Time-Intensity Workgroup.

During the Workgroups discussions at the October 2016 meeting, it was noted that during the Harvard study, the intensity of 0.0081 was derived by expert panel and not from any quantitative analysis. The Workgroup requested for AMA staff to conduct an analyses which looks at variation in scrub/dress/wait (SDW) time across the fee schedule and also which provides the overall scope of how SDW and the other pre-time components impact the fee schedule (included). A letter that ACS submitted to the Research Subcommittee in 2014 with detailed analyses and rationales was also included in the agenda packet for the Workgroup's reference.

At the January meeting, several Workgroup members reiterated that the Harvard study had assigned the intensity value for scrub dress and wait by expert panel. One Workgroup member suggested for the ACS to considering proposing new ideas for valuing S/D/W, such as conducting a survey to attempt to measure the value of S/D/W time. ACS noted that they appreciated the suggestion and will consider sending a future proposal to either the Workgroup or the Research Subcommittee.

The Workgroup chair noted that since these values came from the Harvard study, the RUC could only propose an alternate value to CMS and that it would be CMS decision whether to change the intensity value.

AMA/Specialty Society RVS Update Committee **Tab 08**
Cryoablation of Pulmonary Tumors
Facilitation Committee #2

Members: Doctors Margie Andreae (Chair), Greg DeMeo, Verdi DiSesa, Michael Gerardi, Timothy Laing, Brad Marple, Julia Pillsbury, James Waldorf and Jane White, PhD, RD, FADA.

32998 Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency

The Facilitation Committee reviewed the survey 25the percentile work RVU of 8.00 and survey median work RVU of 9.30. The specialty society indicated that the 25th percentile work RVU was too low to value this service with imaging guidance. The specialty societies indicated and the Committee agreed to crosswalk CPT code 32998 to a similar service that radiologists and interventional radiologists perform, CPT code 47540 *Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)* (work RVU = 9.03 and intra service time of 85 minutes). For additional support, the Committee also referenced CPT code 52355 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor* (work RVU = 9.00 and intra-service time of 90 minutes). **The Facilitation Committee recommends a work RVU of 9.03 for CPT code 32998.**

32X99 Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation

The Facilitation Committee reviewed the survey 25the percentile work RVU of 8.13 and survey median work RVU of 9.30. The specialty society indicated that the 25th percentile work RVU was too low to value this service with imaging guidance. The specialty societies indicated and the Committee agreed to crosswalk CPT code 32X99 to a similar service that radiologists and interventional radiologists perform, CPT code 47540 *Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)* (work RVU = 9.03 and intra service time of 85 minutes). For additional support, the Committee also referenced CPT code 52355 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor* (work RVU = 9.00 and intra-service time of 90 minutes). **The Facilitation Committee recommends a work RVU of 9.03 for CPT code 32X99.**

CPT Code	Eval	Posit	SDW	Intra	Immed Post	Total Time	IWPUT	Rec wRVU
32998	33	10	5	85	30	163	0.0865	9.03
32X99	33	10	5	90	30	168	0.0817	9.03
47540 *Crosswalk*	33	3	5	85	20	146	0.0910	9.03
52355 *Reference*	33	5	15	90	20	163	0.0842	9.00

AMA/Specialty Society RVS Update Committee (RUC) **Tab 14**
Colporrhaphy with Cystourethroscopy
Facilitation Committee #1

Members: George Williams, MD (Chair)**,** James Blankenship, MD**,** Ronald Burd, MD**,** Jimmy Clark, MD**,** David Hitzeman, DO, Walter Larimore, MD**,** Anne Miller-Breslow, MD**,** Guy Orangio, MD**,** Christopher Senkowski, MD**,** Ezequiel Silva, III, MD**,** Doris Tomer, LCSW

57240 ***Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed***
The Facilitation Committee reviewed the survey respondents' estimated physician work valued and agreed that the survey respondents somewhat overvalued the physician work involved, with a 25th percentile RVU of 12.00. To determine an appropriate work RVU, the Committee compared the survey code to MPC code 53850 *Transurethral destruction of prostate tissue; by microwave thermotherapy* (work RVU of 10.08, intra-service time of 60 minutes and total time of 204; RUC reviewed in 2012) and noted that both services involve a similar amount of physician work and have identical intra-service time and similar total time. Therefore, the Committee proposes a direct RVU crosswalk from code 53850 to 57240. The Committee noted that, with this change, the code would have an IWPUT of 0.096, appropriate relative to the top and 2nd key reference codes. To further support the value, the Committee also noted that the proposed value compared favorably to CPT code 19301 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);* (work RVU of 10.13, intra-service time of 60 minutes, total time of 216 minutes). **The Facilitation Committee recommends a work RVU of 10.08 for CPT code 57240.**

57250 ***Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy***
The Facilitation Committee reviewed the survey respondents' estimated physician work valued and agreed that the survey respondents somewhat overvalued the physician work involved, with a 25th percentile RVU of 11.50. To determine an appropriate work RVU, the Committee compared the survey code to MPC code 53850 *Transurethral destruction of prostate tissue; by microwave thermotherapy* (work RVU of 10.08, intra-service time of 60 minutes and total time of 204; RUC reviewed in 2012) and noted that both services involve a similar amount of physician work and have identical intra-service time and similar total time. Therefore, the Committee proposes a direct RVU crosswalk from code 53850 to 57240. The Committee noted that, with this change, the code would have an IWPUT of 0.096, similar to the top and 2nd key reference codes. To further support the value, the Committee also noted that the proposed value compared favorably to CPT code 19301 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);* (work RVU of 10.13, intra-service time of 60 minutes, total time of 216 minutes). **The Facilitation Committee recommends a work RVU of 10.08 for CPT code 57250.**

57260 ***Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;***
The Facilitation Committee reviewed the survey 25th percentile work RVU of 13.25 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 13.25, the Committee compared the survey code to top key reference code 58570 *Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;* (work RVU of 13.36, intra-service time of 90 minutes and total time of 241 minutes; RUC reviewed in 2014) and noted that both services have identical intra-service and total times and both are typically performed in the outpatient setting. The Facilitation Committee noted that the specialty's original recommendation of 13.25 is appropriate relative to the Committee's new proposed values for 57240 and 57250. **The Facilitation Committee recommends a work RVU of 13.25 for CPT code 57260.**

57265 ***Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair***
The Facilitation Committee reviewed the survey 25th percentile work RVU of 15.00 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 15.00, the Committee referenced CPT code **58544** ***Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)*** **(work RVU of 15.60, intra-service time of 120 minutes and total time of 271 minutes)l** and noted that both services have identical intra-service and total times and are both typically performed in the outpatient setting. The Facilitation Committee noted that the specialty's original recommendation of 15.00 is appropriate relative to the Committee's proposed values for the other codes in the family. **The Facilitation Committee recommends a work RVU of 15.00 for CPT code 57265.**

The Facilitation Committee also discussed the practice expense inputs for these services and recommends the direct practice expense inputs as proposed by the Practice Expense Subcommittee.

AMA/Specialty Society RVS Update Committee **Tab 17**
Photodynamic Therapy
Facilitation Committee #3

Members: Stanley Stead, MD (Chair), Dale Blasier, MD, Gregory DeMeo, MD, James Gajewski, MD, Doug Leahy, MD, Alan Lazaroff, Dee Adams Nikjeh, PhD, CCP-SLP, Marc Nuwer, MD, Gregory Przybylski, MD, Marc Raphaelson, MD, Julia Pillsbury, DO, Stephen Sentovich, MD, W. Bryan Sims, DNP

The Facilitation Committee agreed that the coding structure should cover situations both where the photodynamic therapy application was solely performed by clinical labor and also if it was solely performed by a Physician. **To accomplish this, the Committee recommends that PE-only CPT code 96567 should be undeleted and remain zero physician work.** Also, the Committee agreed that the descriptor for 96567 should have an editorial change to "Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s), per day."

96X73 Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day

The Facilitation Committee reviewed the survey 25the percentile work RVU of 0.92 and survey median work RVU of 1.15 and agreed that the survey respondents overvalued the work involved in performing this service. The Committee agreed to crosswalk CPT code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family* (work RVU=0.48, pre= 2 min, intra=10 min, post= 4 min). For additional support, the Committee also referenced CPT code 99201 (work RVU=0.48). Also, the Committee agreed that the global for this code should be 000-day to avoid the potential for billing of same day E/M related to performing the photodynamic therapy service. Further, they recommend that an NCCI edit of "1" should be applied to this code. Also, a CPT parenthetical should be created to prohibit the performance of same-day E/M that is related to the photodynamic therapy; also that it cannot be reported with 96567. **The Facilitation Committee recommends a work RVU of 0.48, a global period of 000-day global and a descriptor change so the service can only be provided by a physician or other QHP. (the work RVU recommendation is contingent on CMS using the 000-day global and that CPT makes the recommended edits).**

96X74 Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and

illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day

The Facilitation Committee reviewed the survey 25the percentile work RVU of 1.25 and survey median work RVU of 1.46 and agreed the survey respondents overestimated the physician work involved in performing this service. The Committee agreed to direct work RVU crosswalk CPT code 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU= 1.01, intra= 15 min, total time= 36 min). Further, they recommend that an NCCI edit of "1" should be applied to this code. Also, a CPT parenthetical should be created to prohibit the performance of same-day E/M that is related to the photodynamic therapy; also that it cannot be reported with 96567. The Committee also noted that the IWPUT of 96X74 should be somewhat higher than 96X73 to account for the more intense physician work involved in performing the debridement. **The Facilitation Committee recommends a work RVU of 1.01 for CPT code 96X74, a global of 000-day and a descriptor change so the service can only be provided by a physician or other QHP. (the work RVU recommendation is contingent on CMS using the 000-day global and that CPT makes the recommended edits).**

Practice Expense

The facilitation committee determined that the current PE inputs for undeleted code 96567 would be the same with the reduction of assist physician performing procedure to 0 minutes and including 10 minutes for the clinical staff to perform the procedure. Also the committee determined that 2 minutes to check dressings & wound/home care instructions/coordinate office visits/prescriptions should be added to CPT 96567. In addition, the intraservice component of the service period to assist physician in performing procedure will be removed from CPT code 96X73 and 96X74.

CPT Code	Eval	Posit	SDW	Intra	Immed Post	Total Time	IWPUT	Rec wRVU	Rec Global
96X73	5	0	0	10	5	20	0.0256	0.48	000
96X74	10	0	0	16	10	36	0.0351	1.01	000