AMA/Specialty RVS Update Committee
Meeting Minutes
January 31-February 1, 2014

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Friday, January 31, 2014 at 8:00 am. The following RUC Members were in attendance:

Barbara Levy, MD
Margie C. Andreae, MD
Michael D. Bishop, MD
James Blankenship, MD
Dale Blasier, MD
Albert Bothe, MD
Ronald Burd, MD
Scott Collins, MD
Thomas Cooper, MD
Anthony Hamm, DC
David F. Hitzeman, DO
Charles F. Koopmann, Jr., MD
Walt Larimore, MD
Alan Lazaroff, MD
M. Douglas Leahy, MD, MACP
J. Leonard Lichtenfeld, MD
Scott Manaker, MD, PhD
William J. Mangold, Jr., MD
Larry Martinelli, MD
Geraldine B. McGinty, MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Sandra Reed, MD
David Regan, MD
Chad A. Rubin, MD, FACS
Peter Smith, MD
Samuel D. Smith, MD
Stanley W. Stead, MD, MBA
J. Allan Tucker, MD
James C. Waldorf, MD
George Williams, MD
Amr Abouleish, MD, MBA*
Allan A. Anderson, MD*
Gregory L. Barkley, MD*
Eileen Brewer, MD*
Gregory DeMeo, MD*
Jane Dillon, MD*
Verdi DiSesa, MD*
William D. Donovan, MD, MPH, FACR*
Jeffrey Paul Edelstein, MD*
Yul Ejnes, MD*
William E. Fox, MD, FACP*
William F. Gee, MD*
Mollie MacCormack, MD*
Daniel McQuillen, MD*
Terry L. Mills, MD*
Eileen Moynihan, MD*
Daniel J. Nagle, MD*
Margaret Neal, MD*
Scott D. Oates, MD*
M. Eugene Sherman, MD*
Samuel Silver, MD*
Holly Stanley, MD*
Robert J. Stomel, DO*
G. Edward Vates, MD*
Jane White, PhD, RD, FADA, LDN*
Jennifer L. Wiler, MD*

*Alternate

II. Chair's Report

- Doctor Levy welcomed everyone to the RUC Meeting.
- Doctor Levy welcomed the following Center for Medicare & Medicaid Services (CMS) staff and representatives attending the meeting:
    - Edith Hambrick, MD – CMS Medical Officer
    - Steve E. Phurrough, MD – CMS Medical Officer
    - Ryan Howe, PhD – Senior Policy Analyst
    - Jessica Bruton, MPA – Health Insurance Specialist
- Doctor Levy welcomed the following Contractor Medical Directors:

  - Charles Haley, MD, MS, FACP
  - Richard W. Whitten, MD, MBA, FACP
  - Ronda Sears, CPC, CPC-H, Noridian Contractor Medical Director Assistant Jurisdiction F.
- Doctor Levy laid out the following guidelines related to RUC proceedings:
  - There is a confidentiality policy that needs to be signed at the registration table for all RUC members and alternates.
  - Proceedings are recorded in order for RUC staff to create the meeting minutes.
  - RUC members must state if they have a conflict of interest before a presentation. That RUC member will not discuss or vote on the issue.
  - RUC members or alternates sitting at the table may not present or debate for their specialty. The RUC is an expert panel and individuals are to exercise their independent judgment and are not advocates for their specialty.
  - RUC members should state their conflict of interest, if applicable, and the member will not discuss or vote on the issue. This will be reflected in our minutes.
- Doctor Levy laid out the following procedural guidelines related to commenting specialty societies:
  - In October 2013, the RUC implemented that the metric to determine who may be "conflicted" to speak to an issue before the RUC be:
    - If a specialty surveyed (LOI=1) or
    - 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 these written comments. It is the discretion of that society if they wish to sit at the table and provide further verbal comments.
- Doctor Levy laid out the following guidelines related to voting:
  - RUC votes are published annually on the AMA RBRVS web site each November for the previous CPT cycle.
  - We vote on every work RVU, including facilitation reports
  - Please share voting remotes with your alternate if you step away from the table
  - To insure we have 28 votes, may necessitate re-voting throughout the meeting
  - If members are going to abstain from voting or leave the table please notify AMA staff so we may account for all 28 votes
- Please note that all meetings are recorded for staff to summarize recommendations to CMS.
- Doctor Przybylski gave the following report of the Financial Disclosure Review Workgroup
  - **Tab 29 Microdissection (88380 & 88381)**
    - Doctor Lee Hilborne from the American Society for Clinical Pathology (ASCP) indicated a financial interest. The Workgroup determined Doctor Hilborne may provide a brief (less than 5 minutes) description of how the procedure is performed. The presenter must then leave the RUC table, but may answer questions from the floor limited to the procedure itself.

III. Director's Report

Sherry L. Smith, MS, CPA, provided the directors report and indicated:

- All RUC participants should have received the new RUC database. AMA staff worked with a vendor to make significant improvements and updates to the RUC database including Mac compatibility.
- We are working to go paperless and will be using SharePoint to distribute the agenda and RUC database. If you have not already, please contact Ruby to establish access to the password protected site.
- The AMA is able to help with media inquiries. Please reach out to the AMA if you are contacted by the media.

IV. Approval of Minutes of the October 3-5, 2013 RUC Meeting

The RUC approved the October 2013 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update (Informational)

Doctor Albert Bothe provided the following update of the CPT Editorial Panel:

- There are two documents provided from the CPT Editorial Panel for your information. The first is the new and revised codes for CPT 2015 as of the end of the last CPT Editorial Panel meeting. The second is CMS requests and RAW issues as they cycle through CPT. Both get updated on a regular basis.
- The CPT Editorial Panel met in mid-October. Doctor Przybylski was the RUC representative. Doctor Kathy Krol is the CPT Editorial Panel representative at this meeting.
- The Panel reviewed 65 code proposals, resulting in 16 agenda items at the RUC. The others were editorial.
- CPT will be meeting next week, there are 100 proposals.
- Some administrative highlights of the CPT meeting included:
    - Total revision of the quantitative drug testing section. The section was revised to make it more intuitive.
    - Updated CPT HCPAC organization and process document to make them current and clear.
    - Clarified the category 3 process. These are Category III (T codes) that do not come to the RUC. The codes are used to define emerging technologies that need to be reported but are not ready of the category 1 distinction.

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

Doctor Edith Hambrick provided the report of the Center for Medicare & Medicaid Services (CMS):

- The Final Rule was published on December 10th, 2013. The comment period is now closed, however anyone is welcome to schedule a meeting with the Agency to discuss specific issues from the Final Rule.
- The Chair of the PE Subcommittee remarked that as part of the misvalued code initiative the practice expense is reviewed in addition to the work. Some of these codes are

captured in the high volume or high expense screens because of very expensive equipment and disposable supplies. An unintended consequence of this review is that the cost of already high cost equipment and disposable supplies continues to escalate in the interim and is reflected in the direct practice expense inputs recommendations. Rebasing the cost of disposable supplies and equipment on a continual basis is not currently part of our process and the Chair urges CMS to consider how the issue can best be addressed.

VII. Contractor Medical Director Update (Informational)

Doctor Charles Haley, CMD, provided the contractor medical director update:

- Contracting environment: In 1997 there were between 50-60 claims paying contractors in the Medicare program and now there are 9 contractors for 12 A/B MAC contracts, 4 DME MAC contracts.
- Policy consistency across contractors: Previously there was a robust process for developing policies, but it was not easy to disseminate across 50-60 contractors. Currently there is greater consistency due to fewer contractors. In addition, CMS stipulates in the contracts that there be collaboration between contractors. One area of collaboration is policy. There are new efforts to develop more consistent policies and the appropriate national societies are involved in these discussions.
    - Some important areas of policy making collaboration that are in comment now include:
        - One clinic lab policy: drugs of abuse testing
        - Two pain management policies: nerve blocks for neuropathy and percutaneous vertebral augmentation
    - Last fall there were also three policies:
        - Two pain management policies: epidural steroid injections and facet joint injections
        - One diagnostic policy: nerve conduction studies.
- Various initiatives to deal with the claims payment error rate program:
    - For Part A, CMS has revised rules and introduced two midnight rule. The contractors are conducting an initiative called probe and education. For these initiatives they will pull a small sample of claims from every hospital in the country to audit and will work with the hospital to make sure they understand the two midnight rule.
    - For Part B, the level of E and M codes continue to be reviewed as this is the driver of payment error rate.

VIII. Washington Update (Informational)

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

- Sustainable Growth Rate (SGR) Status Report
    - 153.7 billion has been spent to patch the SGR
    - It is more fiscally responsible to fix the SGR. The CBO estimates the cost of simple repeal as $117 billion (Dec. 2013), down from nearly $300 billion in 2011
- There are a number of incentives and penalties set to go into effect under current law. Some, like the health information technology, remain positive adjustments, but many are turning negative including e-prescribing. Physicians may or may not benefit on the value-

based modifier (VBM). The VBM penalties will go into effect in 2015 for groups of 100 or more eligible professionals. Increases and decreases in payments are based on cost/quality data measures with 2-year time lag. The penalty increased to 2% for 2015.

- There are bills to repeal the SGR in all three of the Medicare oversight committees:
    - Ways and Means
    - Energy and Commerce
    - Senate Finance Committee

  There is discussion of paying for the repeal with misvalued codes. We have argued that the RUC has already identified the majority of misvalued codes and that that there will not be enough savings to use this as a pay for. The Finance Committee has the highest CBO rating, but this is because of the extenders.
- What is favorable about potential SGR repeal?
    - Bipartisan, bicameral effort
    - Investment by committee leaders, staff
    - Cost down: $298b to $116.5b
    - Focus on policy
    - Time pressure
- What is challenging about potential SGR repeal?
    - Congressional productivity
    - High expectations for support
    - Opposition/Asks from other providers
    - Offsets as deal breakers?
    - Time pressure
- Organized Medicine would not have written this bill, however we believe a fix is better than a patch. Previous patches have resulted in payment freezes, but we believe they will result in reductions in the future. We also believe that it will be some time before Congress revisits this issue; now is the time because of the relatively lower cost of SGR repeal currently.
- Pressure to cut spending may reduce site of service differentials. The AMA/Specialty campaign stopped the plan to cap physician office pay at OPPS/ASC rate for now. Differential updates continue to be higher for hospital payments than for ASC and physician's office, although interest in lowering HOPD to physician office level continues.
- There has been a large jump in observation care claims since 2006. This is possibly prompted by RAC reviews and new readmission penalties. There has been growing pressure to reign in observation care, some of which came from press coverage on the plight of patients denied SNF coverage. CMS attempted to clarify with new two midnight policy but this has created new problems and reduced hospital payments to pay for it. The AMA/AHA joined efforts to press for delay & possibly short stay DRG. The AMA & patient groups are working on SNF problem.
- In the 2014 Final Rule, there were the following changes to the Physician Quality Reporting System (PQRS):
    - For incentive, must report 9 measures (up from 3)
    - Eliminates Administrative claims option and claims-based measure groups
    - Permits reporting through new clinical data registry
- The AMA has been able to secure the following policies for the Physician Quality Reporting System (PQRS):
    - PQRS reporting threshold lowered from 80% of applicable patients to 50%
    - New clinical data registry option finalized

- And is urging the administration to consider the following additional improvements to the Physician Quality Reporting System (PQRS):
    - Better align reporting of MU quality measures with PQRS
    - Improve Qualified Clinical Data Registry option
    - Maintain claims based reporting within PQRS
    - More timely access to PQRS feedback reports
    - Increase the availability of measures for specialties within PQRS
- In the 2014 Final Rule, there were the following changes to Physician Compare:
    - Performance Rates for ACOs and Group Web Reporters to be posted in 2014
- The AMA has been able to secure the following policies for Physician Compare:
    - Phased-in implementation
    - Physicians have 30 days to review and request corrections
    - Opportunity for additional changes
- And is urging the administration to consider the following additional improvements to Physician Compare:
    - Revise rating system
    - Expedite changes to incorrect information
- In the 2014 Final Rule there were the following changes to Value-based Modifier (VBM):
    - Applies VBM to all groups of 10 or more in 2016
    - Increases potential penalty to -2%
    - Adds new cost measure tied to hospital episode
- The AMA has been able to secure the following policies for Value-Based Modifier:
    - Specialty adjustment
    - Ability to appeal Qualified Resource Use Reports (QRUR)
    - Refined QRUR info (e.g., patient information)
    - Individual PQRS reports to avoid VBM penalty
- And is urging the administration to consider the following additional improvements to Value-based Modifier:
    - Further refine specialty adjustment
    - Further refine QRURs
    - Ask Congress for more time and more flexibility
    - Continue to urge Congress to repeal
- The AMA has secured two delays in ICD-10 implementation since 2011 and CMS agreed to a limit testing in March. The AMA is urging Congress to repeal ICD-10 and short of that conduct end-to-end testing prior to the October 1 implementation. The AMA is also urging the administration to activate an advance payment policy to mitigate cash flow and claim processing disruptions. The AMA is also conducting updated cost study readiness of vendors.
- Status Report of Sunshine: Manufacturers began data collection in August 2013 and reports are due to CMS in March, 2014. Physicians are supposed to be able to request notification when data has been reported about them, but the portal has been delayed. The AMA has secured exclusion of CME that complies with certified or accredited CME standards as well as time for physicians to challenge reports expanded to 2 years. If a physician disputes information in report, it will be flagged in public registry. We are currently encouraging the administration to exclude reprints and textbooks as reportable.
- You may have seen press coverage about health plans cutting their physician networks because of ACA reduced overpayments to Medicare Advantage Plans. United/AARP has been most aggressive. This has resulted in access problems. The AMA

joined as amicus on suit challenging the terminations in Connecticut, and the judge did intervene. The AMA is working to add new beneficiary and physician protections.
- There has also been much discussion of problems in implementing the ACA.
- CMS set up mechanism for AMA to convey systemic problems we are seeing. AMA/MGMA created checklist for a physician's office to report recurring problems. Please send to exchangeplans@ama-assn.org. AMA will conduct a survey after first quarter to evaluate landscape.

Questions

- A RUC member asked about reports that unemployment insurance extension will be paid for with 2% cut to Medicare. Sharon reported that this was a gimmick that came out of sequestration, where the 2% cut would be extended. This probably will not go through the Senate.
- A RUC member asked about higher cost specialties that might fail the value based profiles. What specialties and what is this determination based on? Sharon responded that this is a patient mix issue.
- A RUC member commented that we have to keep up the momentum to get the SGR repealed. We also have to work with the AMA to communicate to CMS that tournament system for quality measure payment is unethical.

IX. Creating Higher Quality, More Affordable Health Care under Medicare by Replacing the SGR with Accountable Payment Models (APMs) (Informational)

Sandy Marks, AMA and Harold Miller, Consultant to the AMA, provided the RUC with a presentation about the AMA's work on new physician payment models:

- The AMA has been meeting with physicians and staff from diverse specialty societies to discuss potential development of new payment models. The focus is on new models where there are opportunities to improve care and lower costs simultaneously, especially for conditions that are prevalent in Medicare patients. For example, preventing hospital admissions, reducing the number of operations a patients needs and keeping disease from reaching a more advanced stage.
- The AMA wants to help physicians gain experience with new models, allow them to participate in new models for the segment of their patients that have these conditions while remaining in current system for remainder of their practice.
- In order to move to the next phase of this process, the AMA will meet with additional specialties to identify more APM ideas and further develop concepts with the specialties we are already working with. The goal is to turn several of these ideas into viable proposals for Medicare and other payers to support. The AMA also plans to:
    - Identify resources to help specialties obtain or analyze data to assist in developing their proposals, connect specialties with other groups interested in payment models, such as regional health improvement collaborative.
    - Work with state and local medical societies to help specialties identify practices interested in trial implementation.
    - Draft language for a Request for Proposals that Medicare and other payers could issue.
- To date we have had conversations with policy leaders such as Gail Wilensky and Mark McClellan, two former CMS Administrators and think tanks like the Bipartisan Policy

Center. We have also had conversations with MedPAC, CMS and Congress and will continue seeking pathways to allow implementation of these new models.

- The AMA views specialties as part of the AMA family and believes that we will be good partners and respectful of your internal policies and approval process. Please view the AMA as a resource on new payment models; contact us to discuss your ideas or help you formulate them. The expertise of the RUC and the participating societies could be extremely helpful to this effort and we are excited to get your input today and as we move forward.

Harold Miller, Consultant to the AMA, provided the RUC the following information regarding alternative payment models:

- Current House & Senate SGR Repeal Proposals
    - There has been a lot of discussion of value-based performance (VBP) payment in the proposals and much less discussion of alternative payment models even though a physician who participates in alternative payment models may be exempt from VBP requirements or could receive a larger update for the parts of the practice that continue as fee-for-service.
    - One reason for less discussion is that there are limited alternative payment models available for most physicians today.
- Currently ACOs are the most common alternative payment model, however most ACOs use the same payment models as they did in the past and if there are shared savings they are reinvested in the ACO.
- Although better payment models will result when physicians redesign care and identify payment barriers it is a challenge to get physician voices heard because the CBO has stated that they expect that the greater influence of providers within the design process specified in H.R. 2810 would lead to smaller savings than would arise from the development and adoption of new approaches through the [current] CMMI process.
- We want to bring forward ideas in Washington that shows how to reduce spending without cutting physician payment. We can do this because the majority of spending in Medicare does not go to physician payment but goes to the services that physicians can prescribe, control, or influence.
- Current payment systems force physicians to lose when reducing cost of care for the services that physicians can prescribe, control, or influence, so we want to break that link and introduce accountable payment models that are good for physicians and payers. We also want to avoid long delays in implementing new payment models by implementing and evolving rather than continually testing.
- Accountable payment models we have been exploring include:
    - Acute Conditions
        - Procedure-Based Episode Payment
        - Facility-Independent Procedure Episode
        - Condition-Based Payment for Acute Conditions
        - Diagnostic Bundle for Acute Conditions
        - Diagnostic Bundle + Condition-Based Payment for Acute Conditions
        - Symptom-Based Payment/Condition-Specific Capitation
    - Chronic Conditions
        - Condition-Based Payment for Chronic Conditions
        - Specialty Medical Home
- Currently bundling is the most common alternative payment model, but there are many questions about what services are included/excluded from the service. The warranty

approach that CMS is taking raising the issue of what are the related complications that we are trying to avoid. Accountable models have challenges as well because you have to determine what condition triggers the payment and whom amongst many potential providers is accountable and how should the total payment be allocated among all providers.

- How do we achieve consistency across payers and specialties? We have to think about:
    - The condition or service that triggers the payment
    - The activities and services that are bundled into the payment
    - The method (if any) used to modify payment based on patient acuity
    - The method for determining which provider(s) is accountable for keeping costs within the payment and assuring quality
    - How to allocate the payment among all providers who delivered services covered by the payment
    - How to measure quality of the services delivered with the payment
- Potential roles for RUC & CPT Panel in accountable payment models
    - Defining new codes for bundled and condition-based payments
    - More time-based codes (e.g., month of care management)
    - Setting relative values of bundled and condition-based payments
    - Current methods of setting payments based on "shared savings" will lead to disparities across practices and regions based on historical utilization patterns, and could result in underpaying physicians who now deliver high-value care
    - Adjusting relative values over time as efficiencies and new technologies emerge
    - Establishing clinically meaningful acuity/risk-adjustment methods that are consistent across conditions/specialties
        - Most current acuity/risk-adjustment systems are developed using regression-based analyses of factors that predict current spending patterns,
          not relative levels of physician effort or impacts on outcomes
        - Most risk-adjustment models are intended to work at the global payment level
    - Valuing contributions of multiple physicians inside bundled payments
        - Current RBRVS values may or may not reflect appropriate allocations of effort or practice expenses within team-based models
        - Current attribution models do not appropriately value unpaid services or allow use of team-based models
- Please provide input on the major types of payment models that would be relevant to each specialty and any existing work or past payment models or demonstration projects. Also let us know what help physician practices and specialty societies most need in developing and implementing accountable payment models.

Questions

- A RUC member commented that he is part of a 250 physician primary care group that was part of the pioneer ACO. They are located in Colorado and had the 2nd lowest baseline costs of the pioneer sites. They were forced to drop out after a year because they were being compared to a national sample on rate of growth in costs. The practice ended up doing worse than other practices that actually had higher costs because of a high growth rate in costs. There were also issues in the attribution of patients.

- A RUC member commented that it is very important to emphasize that physician take the lead. A physician led approach in cardiology, smart care, has been very successful. The key is global health of patient linked to global cost.
- A RUC member commented that reduced cost must be linked to malpractice reform. Harold Miller responded that appropriate use criteria, needs to be implemented in conjunction.
- A RUC member commented that the needs of different size practices need to be taken into consideration.
- A RUC member commented on the silos that specialties work within and the need for integration.
- A RUC member commented that in shared savings programs the savings go to the insurance companies and the physicians do not have enough input. There are also major issues with the data and Medicare does not have enough funding for the data needs associated with their programs. Lastly inflation factor hits low cost organizations more heavily.
- A HCPAC member commented that non MD/DO should be included in models for team based care.
- A RUC member commented that in order for this to work we need to adopt universally not just for Medicare patients.
- A RUC member commented that influencing the behavior of individual physicians when it is not good for their pocket book is a significant challenge. Any model needs to address this.
- Patients and the public in general need to be informed about these new payment models or they will be very skeptical.

X. Relative Value Recommendations for *CPT 2015*:

Arthrocentesis (Tab 4)
Thomas Weida, MD (AAFP); William Creevy, MD (AAOS); Zeke Silva, MD (ACR); Timothy Laing, MD (ACRh); Seth Rubenstein, DPM (APMA); Anne Miller, MD (ASSH)

At the October 2013 meeting, the CPT Editorial Panel established three Category I codes and revised three codes to report arthrocentesis with and without imaging guidance. In addition, CPT code 76942 was editorially revised to exclude the new bundled codes.

2060X1 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting
The RUC reviewed the survey results from 104 physicians and recommends the survey 25th percentile work RVU of 0.89 for CPT code 2060X1. The specialty societies indicated and the RUC agreed that 5 minutes pre-service evaluation time, 2 minutes pre-positioning time and 5 minutes pre-scrub/dress/wait time is appropriate (which, includes the provision of administering anesthesia and wait time). The pre-service time is the same as that for the arthrocentesis without ultrasound guidance codes (20600, 20605 and 20610), with an additional minute for positioning of the imaging equipment. The RUC agreed with the survey respondents that 10 minutes of intra-service time and 5 minutes of immediate post-service time adequately account for the physician time required to perform this service. The RUC noted that the physician time for each of the arthrocentesis with ultrasound guidance codes are the same, therefore the increased intensity for each service is based on the increased size of the joint.

The RUC compared the surveyed code to 000-day global services that require 10 minutes of physician intra-service time and determined that the survey 25th percentile work RVU of 0.89 is appropriate relative to these similar services. The CPT codes referenced are: MPC code 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84), MPC code 51705 *Change of cystostomy tube; simple* (work RVU = 0.90), and 50389 *Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)* (work RVU = 1.10). **The RUC recommends a work RVU of 0.89 for CPT code 2060X1.**

2060X2 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting
The RUC reviewed the survey results from 103 physicians and recommends the survey 25th percentile work RVU of 1.00 for CPT code 2060X2. The specialty societies indicated and the RUC agreed that the 5 minutes pre-service evaluation time, 2 minutes pre-positioning time and 5 minutes pre-scrub/dress/wait time is appropriate (which, includes the provision of administering anesthesia and wait time). The pre-service time is the same as that for the arthrocentesis without ultrasound guidance codes (20600, 20605 and 20610), with an additional minute for positioning of the imaging equipment. The RUC agreed with the survey respondents that 10 minutes of intra-service time and 5 minutes of immediate post-service time adequately account for the physician time required to perform this service. The RUC noted that the physician time for each of the arthrocentesis with ultrasound guidance codes are the same, therefore the increased intensity for each service is based on the increased size of the joint.

The RUC noted that the survey 25th percentile work RVU increment between 2060X1 and 2060X2 is approximately the same as the increment difference between 2060X2 and 2060X3. The RUC compared the surveyed code to 000-day global services that require 10 minutes of physician intra-service time and determined that the survey 25th percentile work RVU is appropriate relative to these similar services. The CPT codes referenced are: MPC code 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84), MPC code 51705 *Change of cystostomy tube; simple* (work RVU = 0.90), and 50389 *Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)* (work RVU = 1.10). **The RUC recommends a work RVU of 1.00 for CPT code 2060X2.**

2060X3Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting
The RUC reviewed the survey results from 85 physicians and recommends the survey 25th percentile work RVU of 1.10 for CPT code 2060X3. The specialty societies indicated and the RUC agreed that the pre-service time of 5 minutes pre-service evaluation time, 2 minutes pre-positioning time and 5 minutes pre-scrub/dress/wait time is appropriate (which, includes the provision of administering anesthesia and wait time). The pre-service time is the same as that for the arthrocentesis without ultrasound guidance codes (20600, 20605 and 20610), with an additional minute for positioning of the imaging equipment. The RUC agreed with the survey respondents that 10 minutes of intra-service time and 5 minutes of immediate post-service time adequately account for

the physician time required to perform this service. The RUC noted that the physician time for each of the arthrocentesis with ultrasound guidance codes are the same, therefore the increased intensity for each service is based on the increased size of the joint.

The RUC noted that the survey 25th percentile work RVU increment between 2060X1 and 2060X2 is approximately the same as the increment difference between 2060X2 and 2060X3. The RUC compared the surveyed code to 000-day global services that require 10 minutes of physician intra-service time and determined that the survey 25th percentile work RVU is appropriate relative to these similar services. The CPT codes referenced are: MPC code 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84), MPC code 51705 *Change of cystostomy tube; simple* (work RVU = 0.90), and 50389 *Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)* (work RVU = 1.10). **The RUC recommends a work RVU of 1.10 for CPT code 2060X3.**

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.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

Internal Fixation of Rib Fracture (Tab 5)
Charles Mabry, MD, FACS (ACS); James Levett, MD (STS)

In the Notice for Proposed Rulemaking for 2014, CMS proposed CPT codes 21800, 22305 and 27193 for review. CMS is considering the appropriateness of having a 90-day global surgical package for a procedure that is performed in settings other than the inpatient setting 33 percent of the time. CMS believes it is unlikely that it is appropriate for a procedure performed outside of the inpatient hospital setting at this frequency to have such a long global period. Additionally, in October 2013, the CPT Editorial Panel converted four Category III codes to three Category I codes to report internal fixation of rib fracture and deleted CPT code 21810.

The specialty societies noted that CPT codes 21820 and 21825 are sternal fracture codes and the new codes are rib fracture codes which are not part of the same family of services. Codes 21820 and 21825 are both low volume codes. In addition, 21820 is typically performed by different groups of physicians (eg, emergency medicine) and in different places of service (ie, emergency department or office) compared with the new rib fixation codes. Code 21825 would typically be reported for sternal injuries post cardiac surgery and treatment by cardiothoracic surgeons, whereas trauma surgeons treat the rib injuries represented by the three new codes.

The RUC reviewed the survey responses for CPT codes 2181X1, 2181X2 and 2181X3 and confirmed that a combined targeted and random sample survey was conducted. The RUC noted that less than 30 responses were received for all three surveys. In order to achieve more robust data, the specialty societies requested, and the RUC agreed, to allow the survey process to continue. The RUC instructed the specialty societies to send the surveys to an additional (different) random sample from the society's membership. The

specialty societies will present combined data and data separated by random / non-random as before. **The RUC will review the survey results for CPT codes 2181X1-2181X3 in April 2014.**

Refer to CPT
The specialty society indicated and the RUC agrees to refer low volume CPT codes 21800 and 21805 to the CPT Editorial Panel for deletion.

FEVAR Endograft Planning (Tab 6)
Matthew J. Sideman, MD (SVS)

In February 2013, the CPT Editorial Panel created eight Category I codes to report fenestrated endovascular repair (FEVAR) of the visceral aorta bundled with radiological supervision and interpretation. A subsequent RUC survey revealed extensive pre-service time for endograft planning that occurs over the course of several days or weeks prior to the date of surgery and is outside the guidelines for the 90-day global period. The RUC referred this issue back to CPT. In October 2013, the CPT Editorial Panel created a new code to report the physician planning that occurs prior to the work included in the global period for a patient-specific manufactured fenestrated visceral aortic endograft. The planning includes review of high resolution cross-sectional images (eg, CT, CTA, and MRI) and utilization of 3D software for iterative modelling of the aorta and device in multiplanar views and center line of flow analysis. Additionally, the CPT Editorial Panel editorially revised the exclusionary parenthetical following codes 76376 and 76377 to include the new code.

In January 2014, the specialty societies indicated that the survey response rate was too low to submit a recommendation and requested that these services be carrier priced for two years to allow more widespread use of this newly FDA approved service. **The RUC recommends that CPT codes 348XX9 and 34841-34848 be carrier-priced through CPT 2016 and surveyed for the January 2016 meeting.**

Endoscopic Hypopharyngeal Diverticulotomy (Tab 7)
Wayne Koch, MD (AAO-HNS); John Lanza, MD (AAO-HNS); Peter Manes, MD (AAO-HNS); Francis Nichols, MD (STS)

In October 2013, the CPT Editorial Panel created a new code to describe endoscopic hypopharyngeal diverticulotomy, a common surgical treatment for Zenker's diverticula that was previously reported with an unlisted CPT code.

The RUC reviewed the survey results from 174 otolaryngologists and thoracic surgeons and determined that the survey median of 9.03 work RVUs appropriately accounts for the work required to perform this service. The Committee agreed with the specialty society's recommended 60 minutes pre-time, 60 minutes intra-service time and 20 minutes immediate post-service time. The Committee discussed the post-operative visits and noted that of the respondents stated that the patient is typically kept overnight, however only 36% indicated that they perform an E/M service later on the same day, therefore it is not typical. The specialty society clarified that the 99232 *Subsequent hospital care, per day, for the evaluation and management of a patient* visit should be removed. The Committee confirmed that a full 99238 *Hospital discharge day management* visit is appropriate because the majority of respondents indicated that the patient stays overnight

in the hospital and one 99213 *Office or other outpatient visit for the evaluation and management of an established patient* is typical.

The Committee compared the surveyed service to the key reference service 60220 *Total thyroid lobectomy, unilateral; with or without isthmusectomy* (work RVU = 11.19) and determined that 4319X requires similar intensity and complexity to perform, however requires 30 minutes less intra-service time than 60220, therefore appropriately valued lower. For additional support, the Committee referenced MPC code 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU = 9.23 and 60 minutes intra-service time), 62287 *Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar* (work RVU = 9.03 and 60 minutes intra-service time) and 29905 *Arthroscopy, subtalar joint, surgical; with synovectomy* (work RVU = 9.18). **The RUC recommends a work RVU of 9.03 for CPT code 4319X.**

New Technology
The RUC recommends that CPT code 4319X be placed on the new technology list.

Practice Expense
The RUC recommends the standard 090-day global direct practice expense inputs as approved by the Practice Expense Subcommittee.

<u>Colonoscopy through stoma (Tab 8)</u>
Joel Brill, MD (AGA), Shivan Mehta, MD (AGA), Nicholas Nickl, MD (ASGE), Edward Bentley, MD(ASGE), R. Bruce Cameron, MD (ACG), Guy Orangio, MD (ASCRS),Charles Mabry, MD (ACS), Donald Selzer, MD (SAGES)

Several specific CPT codes identified by CMS through the MPC List screen were scheduled for review at the September 2011 RUC meeting. The RUC review of the codes led to significant concerns with the survey data, and in some cases, coding and payment policy for the individual codes. The specialty societies representing gastroenterology indicated that appropriate surveys could not be conducted until after the specialty societies had an opportunity to clarify the coding and update the descriptors via the CPT Editorial Panel Process. The specialty societies worked with the CPT Editorial Panel and CMS to resolve this coding and payment policy question as it relates to over 100 GI endoscopy services.

In the CPT 2014 cycle, the RUC reviewed all the esophagoscopy, EGD and ERCP families of codes. For the CPT 2015 cycle, the RUC reviewed the illeoscopy, pouchoscopy and flexible sigmoidoscopy services in October 2013 and reviewed colonoscopy and colonoscopy through the stoma procedures in January 2014. In November, 2013, as part of the 2014 Medicare Final Rule, CMS released their work value recommendations on the three families reviewed for the CPT 2014 cycle. It was noted that while CMS disagreed with a majority of the RUC recommendations, the agency seemed to agree that the incremental methodology was the best approach to use in valuing these codes. However, the RUC agreed that CMS often used inappropriate assumptions regarding physician work and intensity and thus offered increments for procedures not in accordance with the appropriate clinical utility either within the

immediate family or within the larger code family. Therefore, as was done in the previous set of codes, the RUC continued to use the incremental methodology as its primary approach to valuing the additional physician work above the base diagnostic procedure. The RUC noted that this methodology was necessary for three reasons. First, given that an entire genre of services is being reviewed, relativity amongst the family is critical. The potential for rank order anomalies is high considering the large amount of codes reviewed in succession. Second, CMS (then HCFA) used the incremental approach in their initial valuation of these services in 1992 and 1993. According to CMS commentary in the Federal Register for those years, the agency established a hierarchy of work from the least to the most difficult endoscopic procedure. Following this, fixed increments were added to the base procedure. Therefore, the RUC determined that these new codes should continue to be valued the same way endoscopic services were initially valued at the creation of the RBRVS. Finally, the RUC has established valuation of physician work through incremental intra-service work as an approved, viable alternate methodology. In fact, endoscopy is listed as an example of this methodology in the RUC's instructions for specialty societies developing work value recommendations.

Prior to reviewing the survey data, the RUC reviewed the valuation history for the entire colonoscopy through stoma (i.e. c-stoma) codes. When 44388 was last reviewed in 2000 as part of the second Five-Year Review, the RUC recognized a rank order anomaly between the colonoscopy through stoma codes and their equivalent colonoscopy codes. At that meeting, the RUC agreed that the value for 44388 should be directly crosswalked to 45378 *Diagnostic Colonoscopy* (CY 2000 work RVU= 3.70) because both services had similar time and physician work intensity. However, CMS did not agree with this value or any of the recommended increases for the colonoscopy through stoma family of codes. Instead the agency chose to accept the RUC recommended physician time components but keep the Harvard work values, thus creating artificially low intensities for the entire c-stoma family. In addition, few codes in the GI endoscopy families have a lower intensity than the c-stoma codes. C-stoma is not screening in nature. It is performed on patients with existing pathology which caused the removal of a portion of the intestinal tract. The area examined may be shorter than a complete colonoscopy, but the examination is still at least as intense as a diagnostic colonoscopy. As will be discussed throughout these recommendations, due to these inconsistencies the RUC agreed that it was inappropriate to further compound the inconsistencies by reducing the current RVUs to account for the reduction in minutes of the survey time compared to the current time.

44388 ***Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed***

The RUC reviewed the survey results of 86 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 26 minutes, intra-service time of 25 minutes and post-service time of 14 minutes. The RUC agreed with the specialties that pre-service package 1B Facility straightforward patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the survey data and concluded that since there is no compelling evidence to increase the value of this procedure, the current work RVU of 2.82, below the survey's 25th percentile is appropriate for CPT code 44388. The RUC specifically noted

that while the intra-service time has dropped from 39 minutes to 25 minutes, the current work RVU of 2.82 should not change. There has been no lessening of the physician work intensity to perform this procedure. Furthermore, reducing the work RVU still further compared to the diagnostic colonoscopy service would only exacerbate the already inaccurate work RVU variance between these two services.

The RUC reviewed the survey's Key Reference Service CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed* (work RVU= 2.78) and noted that even though the reference code has five additional minutes of intra-service time, 30 minutes and 25 minutes, respectively, it is still valued slightly less than 44388. In addition, the RUC reviewed MPC codes 51102 *Aspiration of bladder; with insertion of suprapubic* catheter (work RVU= 2.70, intra time= 20 minutes) and 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU= 2.82, intra time= 25 minutes). These comparison codes, with comparable physician work and times, confirmed to the RUC that the recommended physician times and work values for 44388 are both reasonable and relative to similar services across the RBRVS. **The RUC recommends a work RVU of 2.82 for CPT code 44388.**

44389 *Colonoscopy through stoma; with biopsy, single or multiple*
The RUC reviewed the survey results of 78 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 26 minutes, intra-service time of 30 minutes and post-service time of 14 minutes. The RUC agreed with the specialties that pre-service package 1B Facility straightforward patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey values were too high, with a 25th percentile work RVU of 3.43. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 0.30 in the upper GI endoscopic family of services for the additional work of performing a biopsy over the base diagnostic procedure. Therefore, the RUC added the approved 0.30 work RVUs to CPT code 44388 (RUC recommended work RVU = 2.82) to arrive at a work RVU of 3.12 for 44389. The specialties again explained that while the survey intra-service time of 30 minutes is lower than the current time, when that time was approved in 2000, the RUC had recommended a work RVU of 4.26. Thus, when CMS rejected the RUC's recommendations, and maintained the Harvard value for this procedure, an anomalous discrepancy was created which renders direct work and time comparisons across time inappropriate.

To justify a work RVU of 3.12, the RUC compared recently reviewed CPT code 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU= 3.12) to the surveyed code and noted that both services have identical intra-service time, 30 minutes, and nearly identical total time. Therefore, both services should be valued identically. In addition, the RUC reviewed CPT codes 31623 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings* (work RVU= 2.88) and 62267 *Percutaneous aspiration*

within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes (work RVU= 3.00) and agreed that with comparable physician work and identical intra-service times, 30 minutes, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 3.12 for CPT code 44389.**

44390 ***Colonoscopy through stoma; with removal of foreign body***
The RUC reviewed the survey results of 46 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 37 minutes, intra-service time of 35 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey values were too high, with a 25th percentile work RVU of 4.21. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 1.01 in the upper GI endoscopic family of services for the additional work of removing a foreign body over the base diagnostic procedure. While the RUC agreed with this approach, the specialties noted that adding this increment to the base code would give 44390 a work RVU of 3.83, just higher than the current work RVU of 3.82. Therefore, the RUC agreed that the current work value of 3.82, for 44390 should be maintained. The specialties again explained that while the survey intra-service time of 35 minutes is lower than the current time, when that time was approved in 2000, the RUC had recommended a work RVU of 4.81. Thus, when CMS rejected the RUC's recommendations, and maintained the Harvard value for this procedure, an anomalous discrepancy was created which renders direct work and time comparisons across time inappropriate.

To justify the current work RVU of 3.82, the RUC compared the surveyed code to MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU= 3.80) and agreed that while the reference code has 5 additional minutes of intra-service time, both codes have similar physician work and total times and should be valued almost identically. The RUC also reviewed codes 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30, intra time= 30 minutes) and 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= 3.82, intra time= 40 minutes) and agreed that with similar physician times and work, these two reference services provide appropriate brackets around the recommended work value for 44390. **The RUC recommends a work RVU of 3.82 for CPT code 44390.**

44391 ***Colonoscopy through stoma; with control of bleeding, any method***
The RUC reviewed the survey results of 53 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 40 minutes, intra-service time of 40 minutes and post-service time of

15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the survey's 25th percentile work RVU of 4.22, lower than the current value, accurately values the physician work for code 44391. The RUC noted that while there have been other control of bleeding codes previously reviewed in the upper GI endoscopic family, there is no direct work equivalent between them because the bleeding sites vary between the upper and lower GI tracts. The specialties again explained that while the survey intra-service time of 40 minutes is lower than the current time, when that time was approved in 2000, the RUC had recommended a work RVU of 5.18. Thus, when CMS rejected the RUC's recommendations, and maintained the Harvard value for this procedure, an anomalous discrepancy was created which renders direct work and time comparisons across time inappropriate.

To justify a work RVU of 4.22, the RUC compared the surveyed code to CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous* (work RVU= 4.21) and agreed that since both services have identical intra-service time, 40 minutes, and similar physician work, the two services should be valued almost identically. In addition, the RUC reviewed MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU= 3.80, intra time= 40 minutes) and 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C* (work RVU= 4.74, intra time= 40 minutes) and agreed that with similar physician times and work these two services serve as appropriate brackets around the recommended work value for 44391. **The RUC recommends a work RVU of 4.22 for CPT code 44391.**

44392 ***Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery***

The RUC reviewed the survey results of 50 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 26 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B Facility Straightforward patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey values were too high, with a 25th percentile work RVU of 3.87. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 0.81 in the upper GI endoscopic family of services for the additional work of removing a tumor by

hot biopsy over the base diagnostic procedure. Therefore, the RUC added the approved 0.81 work RVUs to CPT code 44388 (RUC recommended work RVU = 2.82) to arrive at a work RVU of 3.63 for 44392, which is lower than the current value. The specialties again explained that while the survey intra-service time of 30 minutes is lower than the current time, when that time was approved in 2000, the RUC had recommended a work RVU of 4.81. Thus, when CMS rejected the RUC's recommendations, and maintained the Harvard value for this procedure, an anomalous discrepancy was created which renders direct work and time comparisons across time inappropriate.

To justify a work RVU of 3.63, the RUC compared the surveyed code to the Key Reference Service 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that while both codes have identical intra-service time, 30 minutes, 44392 is a more intense procedure and should be valued slightly higher. In addition, the RUC reviewed CPT codes 57461 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix* (work RVU= 3.43, intra time= 28 minutes) and 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal* (work RVU= 4.00, intra time= 30 minutes) and agreed that with similar physician times and work these two services serve as appropriate brackets around the recommended work value for 44392. **The RUC recommends a work RVU of 3.63 for CPT code 44392.**

4439X1 ***Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion (includes pre-and post-dilation and guide wire passage, when performed)***
The RUC reviewed the survey results of 45 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 32 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey's 25th percentile work RVU of 4.44 accurately values this procedure. The RUC noted that the approved increment for ablation with dilation in the upper GI tract is 2.13 work RVUs. However, the specialties explained that performing dilation is not typical in the lower GI tract and should be backed out of the incremental value. Therefore, the RUC subtracted out the value performing a dilation (work RVU= 0.51) and the resulting increment 1.62 was added to the base procedure CPT code 44388 (RUC recommended work RVU = 2.82) to arrive at a work RVU of 4.44 for 4439X1, which is identical to the 25th percentile.

To justify a work RVU of 4.44, the RUC compared the surveyed code to CPT code 52234 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)* (work RVU= 4.62) and noted that while both codes have identical intra-service time, 30 minutes, the reference code has greater total time and should thus be valued slightly higher than 4439X1. In addition, the RUC reviewed CPT codes 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17, intra time= 30 minutes) and 59070 *Transabdominal*

amnioinfusion, including ultrasound guidance (work RVU= 5.24, intra time= 30 minutes) and agreed that with similar physician times and work these two services serve as appropriate brackets around the recommended work value for 4439X1. **The RUC recommends a work RVU of 4.44 for CPT code 4439X1.**

44394 ***Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique***
The RUC reviewed the survey results of 60 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 27 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey values were too high, with a 25th percentile work RVU of 4.20. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 1.31 in the upper GI endoscopic family of services for the additional work of removing a tumor by snare over the base diagnostic procedure. Therefore, the RUC added the approved 1.31 work RVUs to CPT code 44388 (RUC recommended work RVU = 2.82) to arrive at a work RVU of 4.13 for 44394, which is lower than the current value.

To justify a work RVU of 4.13, the RUC compared the surveyed code to CPT code 31629 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (work RVU= 4.09) and agreed that since both codes have identical intra-serive time, 30 minutes, and comparable physician work, both services should be valued almost identically. In addition, the RUC reviewed MPC code 52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy* (work RVU= 4.05, intra time= 30 minutes) and code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17, intra time= 30 minutes) and agreed that with similar physician times and work these two services serve as appropriate brackets around the recommended work value for 44394. **The RUC recommends a work RVU of 4.13 for CPT code 44394.**

4439X2 ***Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guidewire passage, when performed)***
The RUC reviewed the survey results of 40 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 40 minutes, intra-service time of 43 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey values were too high, with a median work RVU of 5.80. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 2.14 in the upper GI endoscopic family of services for the additional work of placing a stent over the base diagnostic procedure. Therefore, the RUC added the approved 2.14 work RVUs to CPT code 44388 (RUC recommended work RVU = 2.82) to arrive at a work RVU of 4.96 for 4439X2.

To justify a work RVU of 4.96, the RUC compared the surveyed code to CPT code 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C* (work RVU= 4.74) and agreed that since the surveyed code has 3 additional minutes of intra-service time, 43 minutes compared to 40 minutes, and slightly greater total time, 4439X2 is appropriately valued higher than this reference code. In addition, the RUC reviewed CPT codes 50385 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 4.44, intra time= 45 minutes) and 36246 *Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 5.27, intra time= 45 minutes) and agreed that with similar physician times and work these two services serve as appropriate brackets around the recommended work value for 4439X2. **The RUC recommends a work RVU of 4.96 for CPT code 4439X2.**

4439X3 *Colonoscopy through stoma; with endoscopic mucosal resection*

The RUC reviewed the survey results of 40 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 32 minutes, intra-service time of 45 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey values were too low compared to the approved incremental methodology approach. The RUC previously established a work RVU of 2.99 in the upper GI endoscopic family of services for the additional work of performing endoscopic mucosal resection over the base diagnostic procedure. Therefore, the RUC added the approved 2.99 work RVUs to CPT code 44388 (RUC recommended work RVU = 2.82) to arrive at a work RVU of 5.81 for 4439X3.

To justify a work RVU of 5.81, the RUC compared the surveyed code to CPT code 52351 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic* (work RVU= 5.75) and although the reference code has greater pre-service time, both services have identical intra-service time, 45 minutes, and comparable physician work. Therefore, 4439X3 should be valued nearly the same as 52351. In addition the RUC reviewed CPT codes 36246 *Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 5.27, intra time= 45 minutes) and 93458 *Catheter placement in coronary artery(s)*

for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed (work RVU= 5.85, intra time= 45 minutes) and agreed that with similar physician times and work these two services serve as appropriate brackets around the recommended work value for 4439X3. **The RUC recommends a work RVU of 5.81 for CPT code 4439X3.**

4439X4 ***Colonoscopy through stoma; with directed submucosal injection(s), any substance***
The RUC reviewed the survey results of 47 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 26 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B Facility Straightforward patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey values were too high, with a 25th percentile work RVU of 3.61. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 0.31 in the upper GI endoscopic family of services for the additional work of performing a submucosal injection over the base diagnostic procedure. Therefore, the RUC added the approved 0.31 work RVUs to CPT code 44388 (RUC recommended work RVU = 2.82) to arrive at a work RVU of 3.13 for 4439X4.

To justify a work RVU of 3.13, the RUC compared the surveyed code to CPT code 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU= 3.12) and agreed that since both service have identical intra-service time, 30 minutes, and nearly identical total time, both services should be valued nearly identical to each other. In addition, the RUC reviewed CPT codes codes 31623 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings* (work RVU= 2.88, intra time= 30 minutes) and 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30, intra time= 30 minutes) and agreed that with similar physician times and work these two services serve as appropriate brackets around the recommended work value for 4439X4. **The RUC recommends a work RVU of 3.13 for CPT code 4439X4.**

4439X5 ***Colonoscopy through stoma; with transendoscopic balloon dilation***
The RUC reviewed the survey results of 40 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 32 minutes, intra-service time of 38 minutes and post-service time of 12 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the

endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey values were too high, with a 25th percentile work RVU of 4.55. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 0.51 in the upper GI endoscopic family of services for the additional work of performing balloon dilation over the base diagnostic procedure. Therefore, the RUC added the approved 0.51 work RVUs to CPT code 44388 (RUC recommended work RVU = 2.82) to arrive at a work RVU of 3.33 for 4439X5.

To justify a work RVU of 3.33, the RUC compared the surveyed code to 49446 *Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 3.31) and noted that while the reference code has greater total time compared to 4439X5, 93 minutes and 82 minutes, respectively, the surveyed code is a more intense procedure and should be valued slightly higher. In addition, the RUC reviewed MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU= 3.80, intra time= 40 minutes) and code 12017 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm* (work RVU= 3.18, intra time= 40 minutes) and agreed that with similar physician times and work these two services serve as appropriate brackets around the recommended work value for 4439X5. **The RUC recommends a work RVU of 3.33 for CPT code 4439X5.**

4439X6 ***Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures***

The RUC reviewed the survey results of 35 gastroenterologists and recommends the following physician time components: pre-service time of 40 minutes, intra-service time of 40 minutes and post-service time of 20 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey values were too high, with a median work RVU of 4.50. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 1.59 in the upper GI endoscopic family of services for the additional work of performing a endoscopic ultrasound examination over the base diagnostic procedure. Therefore, the RUC added the approved 1.59 work RVUs to CPT code 44388 (RUC recommended work RVU = 2.82) to arrive at a work RVU of 4.41 for 4439X6.

To justify a work RVU of 4.41, the RUC compared the surveyed code to 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and*

interpretation, percutaneous (work RVU= 4.21) and noted that even though both services have identical intra-service time, 40 minutes, 4439X6 is a slightly more complex codes and should therefore be valued higher. In addition, the RUC reviewed CPT codes 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= 3.82, intra time= 40 minutes) and 58562 *Hysteroscopy, surgical; with removal of impacted foreign body* (work RVU= 5.20, intra time= 40 minutes) and agreed that with similar physician times and work these two services serve as appropriate brackets around the recommended work value for 4439X6. **The RUC recommends a work RVU of 4.41 for CPT code 4439X6.**

4439X7 ***Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures***

The RUC reviewed the survey results of 32 gastroenterologists and recommends the following physician time components: pre-service time of 40 minutes, intra-service time of 60 minutes and post-service time of 20 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey values were too high, with a median work RVU of 5.25. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 2.24 in the upper GI endoscopic family of services for the additional work of performing a endoscopic ultrasound examination with fine needle aspiration over the base diagnostic procedure. Therefore, the RUC added the approved 2.24 work RVUs to CPT code 44388 (RUC recommended work RVU = 2.82) to arrive at a work RVU of 5.06 for 4439X7.

To justify a work RVU of 5.06, the RUC compared the surveyed code to 52327 *Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material* (work RVU= 5.18) and agreed that while both services have identical intra-service time, 60 minutes, the reference code should be valued slightly higher due to greater total time, 135 minutes compared to 120 minutes. In addition, the RUC reviewed CPT codes 93642 *Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)* (work RVU= 4.88, intra time= 60 minutes) and 57155 *Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy* (work RVU= 5.40, intra time= 60 minutes) and agreed that with similar physician times and work these two services serve as appropriate brackets around the recommended work value for 4439X7. **The RUC recommends a work RVU of 5.06 for CPT code 4439X7.**

4439X8 ***Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed***

The RUC reviewed the survey results of 53 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 40 minutes, intra-service time of 40 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with one additional minute over the standard to account for supine positioning of the patient and removal of stomal appliance or clip to allow stomal access through the appliance, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialties that the survey's 25th percentile work RVU of 4.24 accurately values this procedure. The RUC noted that there is not currently an approved increment in the upper GI tract for the placement of a decompression tube. To justify a work RVU of 4.24, the RUC compared the surveyed code to CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous* (work RVU= 4.21) and agreed that since both services have identical intra-service time, 40 minutes, and similar physician work, the two services should be valued almost identically. In addition, the RUC reviewed CPT codes 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= 3.82, intra time= 40 minutes) and 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C* (work RVU= 4.74, intra time= 40 minutes) and agreed that with similar physician times and work these two services serve as appropriate brackets around the recommended work value for 4439X8. **The RUC recommends a work RVU of 4.24 for CPT code 4439X8.**

Practice Expense:
The Practice Expense Subcommittee reviewed the direct practice expense inputs for the colonoscopy services and noted that these services mostly crosswalk from the flexible sigmoidoscopy codes approved for 2014. In general, the total clinical staff times were slightly lower than the current inputs. The largest change was the addition of 30 minutes for staff to clean the scope. There were several modifications to supplies for a small subset of codes to match refinements made to the flexible sigmoidoscopy codes approved in the previous year. The RUC approved the revised PE spreadsheet as modified 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.

Flexible Sigmoidoscopy (Tab 9)
Joel Brill, MD(AGA), Shivan Mehta, MD (AGA), Nicholas Nickl, MD (ASGE), Edward Bentley, MD (ASGE), R. Bruce Cameron, MD (ACG), Guy Orangio, MD (ASCRS), Christopher Senkowski, MD (ACS), Donald Selzer, MD (SAGES)

Several specific CPT codes identified by CMS through the MPC List screen were scheduled for review at the September 2011 RUC meeting. The RUC review of the codes

led to significant concerns with the survey data, and in some cases, coding and payment policy for the individual codes. The specialty societies representing gastroenterology indicated that appropriate surveys could not be conducted until after the specialty societies had an opportunity to clarify the coding and update the descriptors via the CPT Editorial Panel Process. The specialty societies worked with the CPT Editorial Panel and CMS to resolve this coding and payment policy question as it relates to over 100 GI endoscopy services.

In the CPT 2014 cycle, the RUC reviewed all the esophagoscopy, EGD and ERCP families of codes. For the CPT 2015 cycle, the RUC reviewed the illeoscopy, pouchoscopy and flexible sigmoidoscopy services in October 2013 and reviewed colonoscopy and colonoscopy through the stoma procedures in January 2014. (Note, a few of the flexible sigmoidoscopy services were reviewed in January 2014 as well.) Given that this process will require the RUC and specialty societies to survey and review the entire family of endoscopy procedures, the RUC has consistently maintained that relativity within both the immediate and larger family is of paramount importance. As was done in the previous set of codes, the RUC used an incremental methodology to value the additional physician work above the base diagnostic procedure. The RUC noted that this methodology was necessary for three reasons. First, given that an entire genre of services is being reviewed, relativity amongst the family is critical. The potential for rank order anomalies is high considering the large amount of codes reviewed in succession. Second, CMS (then HCFA) used the incremental approach in their initial valuation of these services in 1992 and 1993. According to CMS commentary in the Federal Register for those years, the agency established a hierarchy of work from the least to the most difficult endoscopic procedure. Following this, fixed increments were added to the base procedure. Therefore, the RUC determined that these new codes should continue to be valued the same way endoscopic services were initially valued at the creation of the RBRVS. Finally, the RUC has established valuation of physician work through incremental intra-service work as an approved, viable alternate methodology. In fact, endoscopy is listed as an example of this methodology in the RUC's instructions for specialty societies developing work value recommendations.

45330 Sigmoidoscopy, flexible; diagnostic, collection of specimen(s) by brushing or washing when performed

The RUC reviewed the survey results of 103 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 21 minutes, intra-service time of 10 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1A Facility straightforward patient and procedure without sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialty societies that 45330 is currently overvalued, with a work RVU of 0.96. Since the survey respondents overestimated the physician work, the RUC reviewed CPT code 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU= 0.84) and agreed that since both these services have identical intra-service time and similar work intensity, they should be valued identically. The RUC agreed that a work RVU of 0.84, a direct crosswalk to code 12001, appropriately valued 45330 to similar services across the RBRVS.

To justify a work RVU of 0.84, the RUC compared the surveyed code to MPC codes 45300 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing* (work RVU= 0.80, intra time= 10 minutes) and 43760 *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance* (work RVU= 0.90, intra time= 10 minutes) and noted that both these services are similar services with highly analogous times. Therefore, a recommended value of 0.84 appropriately values 45330 in between these MPC services. Finally, to ensure relativity within the endoscopic family, the RUC noted that the recommended RVU of 0.84 places diagnostic flexible sigmoidoscopy appropriately below diagnostic ileoscopy (RUC recommended work RVU= 0.97) and diagnostic esophagoscopy (RUC recommended work RVU= 1.59) in terms of comparative physician work. **The RUC recommends a work RVU of 0.84 for CPT code 45330.**

45331 Sigmoidoscopy, flexible; with biopsy, single or multiple
The RUC reviewed the survey results of 100 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 21 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1A Facility straightforward patient and procedure without sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45331. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy biopsy code, 43202 (RUC recommended work RVU= 1.89) should be maintained in this flexible sigmoidoscopy biopsy code. Therefore, the established increment for the physician work related to the biopsy, 0.30 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.14 for CPT code 45331. The RUC agreed with the specialty that the physician work related solely to biopsy is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.14, the RUC compared the surveyed code to CPT codes 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU= 1.10) and 36584 *Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access* (work RVU= 1.20) and agreed that since both codes have identical intra-service time to 45331, 15 minutes, and similar total time, the recommended value appropriately values the surveyed code between these two reference codes. Finally, the RUC reviewed MPC code 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU= 1.01) in comparison to 45331and noted that while both services have 15 minutes of intra-service time, the surveyed code has more total time than this reference code, 46 minutes compared to 36 minutes, and is thus appropriately valued more. **The RUC recommends a work RVU of 1.14 for CPT code 45331.**

45332 Sigmoidoscopy, flexible; with removal of foreign body
The RUC reviewed the survey results of 64 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because FB removal involves removal of a stent, or devices of various sizes and shapes, in a patient with a narrowing or obstruction of the lumen of the bowel typically resulting from a neoplasm, ischemia, radiation, inflammatory bowel disease, or severe angulation of the bowel.

The RUC first considered three compelling evidence arguments to consider a change in the current work RVU of 1.79 for this service: Change in site-of-service, change in technology and change in types of foreign bodies. There has been a change in the site-of-service for this procedure as 25 years ago, removal of rectal foreign bodies that often required removal under General Anesthesia in the operating room using a rigid proctoscope are now removed in the outpatient setting using a flexible sigmoidoscope. Additionally, new technology for retrieval of rectal foreign bodies is now in use since the prior valuation, including retrieval nets and foreign body balloons. Finally, there are now medical devices requiring removal which did not exist at the prior valuation, including fully coated removable self-expanding metal stents and prostate massage devices for treatment of lower urinary tract symptoms such as benign prostatic hyperplasia, chronic prostatitis/chronic pelvic pain syndrome or bladder conditions such as interstitial cystitis. The variety of rectal foreign bodies inserted by patients are larger, more complex, and more numerous since the prior valuation of this code. The RUC agreed with the specialty societies that there is compelling evidence to consider a change in the current work value for 45332.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45332. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy removal of foreign body code, 43215 (RUC recommended work RVU= 2.60) should be maintained in this flexible sigmoidoscopy hot biopsy code. Therefore, the established increment for the physician work related to removal of a foreign body, 1.01 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.85 for CPT code 45332. The RUC agreed with the specialty that the physician work related solely to foreign body removal is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.85, the RUC compared the surveyed code to CPT codes 32554 *Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance* (work RVU= 1.82) and 45317 *Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* (work RVU= 2.00) and agreed that since both services have

identical intra-service time, 20 minutes, and comparable physician work, the recommended work RVU of 1.85 appropriately values 45332 in between these two reference services. The RUC also reviewed MPC code 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, intra time= 20 minutes) and agreed that this reference code should be valued slightly less than the surveyed code due to less total time, 59 minutes and 63 minutes). **The RUC recommends a work RVU of 1.85 for CPT code 45332.**

45333 Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
The RUC reviewed the survey results of 59 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B Facility straightforward patient and procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45333. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy hot biopsy code, 43216 (RUC recommended work RVU= 2.40) should be maintained in this flexible sigmoidoscopy hot biopsy code. Therefore, the established increment for the physician work related to the hot biopsy, 0.81 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.65 for CPT code 45333. The RUC agreed with the specialty that the physician work related solely to hot biopsy is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.65, the RUC compared the surveyed to CPT code 64448 *Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)* (work RVU= 1.63, total time= 55 minutes) and agreed that since both services have identical intra-service time, 15 minutes, and analogous total time, the two services should be valued similarly. The RUC also reviewed two MPC codes 57452 *Colposcopy of the cervix including upper/adjacent vagina* (work RVU= 1.50) 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 agreed that since both codes have identical intra-service time, and similar total time, compared to 45333, the recommended work value of 1.65 appropriately values this surveyed code between these two reference codes. **The RUC recommends a work RVU of 1.65 for CPT code 45333.**

45334 Sigmoidoscopy, flexible; with control of bleeding, any method
The RUC reviewed the survey results of 71 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two

additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient, who may have significant comorbidity, coagulation defects and/or hemodynamic instability, has active gastrointestinal bleeding typically resulting from diverticula, neoplasia, ischemia, radiation, or inflammatory bowel disease.

The RUC reviewed the estimated work values and agreed with the specialty societies that the current work RVU of 2.73 overstates the physician work involved in 45334. Since there is no previously established increment for control of bleeding, the RUC reviewed the survey's 25th percentile and determined that a work RVU of 2.10 accurately values this service relative to similar codes in the endoscopic family. To justify a work RVU of 2.10, the RUC compared the surveyed code to CPT codes 49084 *Peritoneal lavage, including imaging guidance, when performed* (work RVU= 2.00) and 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix* (work RVU= 2.20) and agreed that since both codes have identical intra-service time, 20 minutes, and similar total time, compared to 45334, the recommended work value of 2.10 appropriately values this surveyed code between these two reference codes. The RUC also reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70, total time= 60 minutes) and agreed that while the two services have identical intra time and analogous total time, the MPC code should be valued higher than 45334 due to greater physician and intensity to perform the service. **The RUC recommends a work RVU of 2.10 for CPT code 45334.**

45335 Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
The RUC reviewed the survey results of 63 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B Facility straightforward patient and procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45335. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy submucosal injection code, 43201 (RUC recommended work RVU= 1.90) should be maintained in this flexible sigmoidoscopy submucosal injection code. Therefore, the established increment for the physician work related to the submucosal injection, 0.31 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.15 for CPT code 45335. The RUC agreed with the specialty that the physician work related solely to submucosal injection is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.15, the RUC compared the surveyed CPT code 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU= 1.01) and MPC code 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 agreed that since these codes all have identical intra-service time, 15 minutes, and provide appropriate reference codes, from across the RBRVS, to bracket the recommended work RVU of 1.15 for 45335. The RUC also reviewed CPT code 57500 *Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)* (work RVU= 1.20, intra time= 15 minutes) and noted that even though the reference code has less pre- and post-service time than 45335, it should still be valued slightly higher due to greater intensity and complexity in the physician work. **The RUC recommends a work RVU of 1.15 for CPT code 45335.**

45337 Sigmoidoscopy, flexible; with decompression of volvulus, any method
The RUC reviewed the survey results of 63 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 38 minutes, intra-service time of 25 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient, who may have debility, comorbidity, altered mental status, and/or neurologic deterioration, has a severe megacolon typically resulting from neoplasia, ischemia, strictures, or intestinal motility dysfunction.

The RUC reviewed the estimated work values and agreed with the specialty societies that the current work RVU of 2.36 overstates the physician work involved in 45337. Since there is no established increment for this procedure, the RUC reviewed the survey's 25th percentile and determined that a work RVU of 2.20 accurately values this service relative to similar codes in the endoscopic family. To justify a work RVU of 2.20, the RUC compared the surveyed code to CPT codes 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU= 2.00) and 64517 *Injection, anesthetic agent; superior hypogastric plexus* (work RVU= 2.20) and agreed that since both codes have identical intra-service time, 25 minutes, and similar total time, compared to 45337, the recommended work value of 2.20 appropriately values this surveyed code between these two reference codes. The RUC also reviewed CPT code 45321 *Proctosigmoidoscopy, rigid; with decompression of volvulus* (work RVU= 1.75, intra time= 20 minutes) and noted that while the physician work is comparable, the reference code is appropriately valued less than 45337 because it has 5 minutes less intra-service time. **The RUC recommends a work RVU of 2.20 for CPT code 45337.**

45338 Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
The RUC reviewed the survey results of 67 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient has polypoid lesions typically resulting from a neoplasia, pre-neoplasia, or inflammatory bowel disease.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45338. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy snare code, 43217 (RUC recommended work RVU= 2.90) should be maintained in this flexible sigmoidoscopy snare code. Therefore, the established increment for the physician work related to the snare, 1.31 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 2.15 for CPT code 45338. The RUC agreed with the specialty that the physician work related solely to the snare is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 2.15, the RUC compared the surveyed code to CPT codes 69801*Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (work RVU= 2.06) and 92960 *Cardioversion, elective, electrical conversion of arrhythmia; external* (work RVU= 2.25) and agreed that since both codes have identical intra-service time, 15 minutes, and similar total time, compared to 45338, the recommended work value of 2.15 appropriately values this surveyed code between these two reference codes. The RUC also reviewed MPC code 52000 *Cystourethroscopy (separate procedure)* (work RVU= 2.23, total time= 42 minutes) and noted that while this reference code has less pre- and post-service time compared to 45338, this reference code is appropriately valued higher because the service requires greater intensity and complexity to perform. **The RUC recommends a work RVU of 2.15 for CPT code 45338.**

4534X6 Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
The RUC reviewed the survey results of 49 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient has lesions typically resulting from neoplasia, pre-neoplasia, inflammatory bowel disease, or radiation.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 4534X6. The RUC noted that the identical increment between the esophagoscopy gastroscopy duodenoscopy (EGD) base code, 43235 (RUC recommended work RVU= 2.26) and the EGD ablation code, 43270 (RUC recommended work RVU= 4.39) should be maintained in this flexible sigmoidoscopy ablation code. Therefore, the established increment for the physician work related to the ablation, 2.13 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 2.97 for CPT code 4534X6. The RUC agreed with the specialty that the physician work related solely to ablation is not correlated to the work

intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 2.97, the RUC compared the surveyed code to CPT codes 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 2.86) and 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that since both codes have identical intra-service time, 20 minutes, and similar total time, compared to 4534X6, the recommended work value of 2.97 appropriately values this surveyed code between these two reference codes. The RUC also reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70, total time= 60 minutes) and agreed that while the two services have identical intra time and analogous total time, the surveyed code should be valued slightly higher than this MPC code due to greater physician and intensity to perform the service. **The RUC recommends a work RVU of 2.97 for CPT code 4534X6.**

45340 Sigmoidoscopy, flexible; with transendoscopic balloon dilation
The RUC reviewed the survey results of 58 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient has an intermittent bowel obstruction typically resulting from a neoplasm, ischemia, or inflammatory bowel disease.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45340. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy balloon dilation less than 30 mm code, 43220 (RUC recommended work RVU= 2.10) should be maintained in this flexible sigmoidoscopy balloon dilation code. Therefore, the established increment for the physician work related to balloon dilation, 0.51 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.35 for CPT code 45340. The RUC agreed with the specialty that the physician work related solely to balloon dilation is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.35, the RUC compared the surveyed code to CPT codes 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report* (work RVU= 1.28) and 32560 *Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)* (work RVU= 1.54) and agreed that since both codes have identical intra-service time, 20 minutes, and similar total time, compared to 45340, the recommended work value of 1.35 appropriately values this surveyed code between these two reference codes. Finally, the RUC reviewed MPC code 12002 *Simple repair of superficial wounds*

of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm (work RVU= 1.14) and agreed that that since this code has less intra-service time, 15 minutes, compared to 45340, the recommended value of 1.35 accurately values this surveyed code higher than this MPC code. **The RUC recommends a work RVU of 1.35 for CPT code 45340.**

45341 Sigmoidoscopy, flexible; with endoscopic ultrasound examination
The RUC reviewed the survey results of 36 gastroenterologists and recommends the following physician time components: pre-service time of 38 minutes, intra-service time of 30 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the typical patient has previously found squamous cell carcinoma of the anus and flexible sigmoidoscopy with EUS is needed to stage the lesion.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45341. The RUC noted that the identical increment between the esophagoscopy gastroscopy duodenoscopy (EGD) base code, 43235 (RUC recommended work RVU= 2.26) and the EGD EUS code, 43237 (RUC recommended work RVU= 3.85) should be maintained in this flexible sigmoidoscopy equivalent code. Therefore, the established increment for the physician work related to EUS, 1.59 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 2.43 for CPT code 45341. The RUC agreed with the specialty that the physician work related solely to EUS is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 2.43, the RUC compared the surveyed code to CPT code 52005 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service* (work RVU= 2.37) and agreed that since both codes have identical intra-service time, 30 minutes, and analogous total time, both services should be valued nearly identically. In addition, the RUC reviewed CPT code to MPC code 11043 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less* (work RVU= 2.70) and noted that since the reference code has slightly more total time and more physician work intensity, code 11043 is appropriately valued greater than 45341. **The RUC recommends a work RVU of 2.43 for CPT code 45341.**

45342 Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
The RUC reviewed the survey results of 36 gastroenterologists and recommends the following physician time components: pre-service time of 41 minutes, intra-service time of 45 minutes and post-service time of 20 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult

patient because the typical patient has previously found squamous cell carcinoma of the anus and flexible sigmoidoscopy with EUS and FNA is needed to stage the lesion.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45342. The RUC noted that the identical increment between the esophagoscopy gastroscopy duodenoscopy (EGD) base code, 43235 (RUC recommended work RVU= 2.26) and the EGD EUS with FNA code, 43238 (RUC recommended work RVU= 4.50) should be maintained in this flexible sigmoidoscopy equivalent code. Therefore, the established increment for the physician work related to EUS with FNA, 2.24 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 3.08 for CPT code 45342. The RUC agreed with the specialty that the physician work related solely to EUS with FNA is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 3.08, the RUC compared the surveyed code to CPT code 59001 *Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)* (work RVU= 3.00) and agreed that with identical intra-service time, 45 minutes, and similar work intensity, both codes should be valued similarly. In addition, the RUC reviewed CPT code 36595 *Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access* (work RVU= 3.59) and noted that while both codes have the same intra-service time, the reference code is more intense and justifies a higher work value than 45342. **The RUC recommends a work RVU of 3.08 for CPT code 45342.**

4534X7 Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
The RUC reviewed the survey results of 57 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 41 minutes, intra-service time of 35 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the reason for placement of a stent is that the patient has a narrowing or obstruction of the lumen of the bowel resulting from a neoplasm.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 4534X7. The RUC noted that the identical increment between the esophagoscopy gastroscopy duodenoscopy (EGD) base code, 43235 (RUC recommended work RVU= 2.26) and the EGD endoscopic stent placement code, 43266 (RUC recommended work RVU= 4.40) should be maintained in this flexible sigmoidoscopy endoscopic stent placement code. Therefore, the established increment for the physician work related to endoscopic stent placement, 2.14 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 2.98 for CPT code 4534X7. The RUC agreed with the specialty that the physician work

related solely to placement of an endoscopic stent is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 2.98, the RUC compared the surveyed code to CPT code 37214 *Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method* (work RVU= 2.74) and noted that while the reference code has greater intra-service time, 38 minutes compared to 35 minutes, the physician work involved in 4534X7 is more intense and complex than in the reference code. Therefore, the surveyed code is accurately valued higher than this reference code. The RUC also reviewed MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU= 3.80) and agreed that with higher intra-service time, 40 minutes, the reference code is accurately valued higher than 4534X7. **The RUC recommends a work RVU of 2.98 for CPT code 4534X7.**

G0104 ***Colorectal cancer screening; flexible sigmoidoscopy***
HCPCS code G0104 was created in 1998 by CMS as a mechanism to identify a screening service for which there was a newly approved Medicare benefit, and to ensure that frequency limits could be monitored during claims adjudication. Each G-code has a matched Category I CPT code with exactly the same physician work, same practice expense details, and same payment. CMS and other third-party payors have maintained throughout the history of these codes that there is no difference in physician work between these codes are their corresponding CPT codes. The RUC agreed with the specialty societies that colonoscopy, as defined by CPT, is the same procedure whether it is performed on a patient with a family history of cancer (ie, high risk); on an asymptomatic patient as a preventative service (ie, not meeting criteria for high risk); or on a patient with a prior history of polyp removal. For each of these patients, the same flexible sigmoidoscopy procedure is performed by the provider, as clearly defined in the revised CPT guidelines. **Therefore, the RUC recommends a work RVU of 0.84 for G0104, a direct crosswalk to CPT code 45330.**

Practice Expense:
The Practice Expense Subcommittee reviewed the direct practice expense inputs for the flexible sigmoidoscopy services and noted that these services mostly crosswalk from the EGD codes approved last year. In general, the total clinical staff times were either slightly lower or just about the same as the current inputs. The largest change was the addition of 30 minutes for staff to clean the scope. There were several modifications to supplies for a small subset of codes to match refinements made to the EGD codes approved in the previous year. Finally, the Subcommittee noted that several supplies and equipment were newly submitted to CMS for pricing just last year. Since new codes were not available prior to the meeting, they are listed as new and will be revised when CMS releases the codes. There is one new equipment item specifically related to these types of procedures (videoscope, sigmoidoscopy) and one item related to only CPT code 43270 (radiofrequency generator, endoscopy). Appropriate invoices are attached. The RUC approved the revised PE spreadsheet as modified by the PE Subcommittee.

Extant Databases:
The RUC is aware that several databases currently exist that collect physician time and other patient quality-related information for endoscopy services. The specialty societies were queried about the availability of these databases to be used to inform the RUC during this extensive review of all endoscopy procedures. The specialties explained that these databases currently do not have a standard definition of intra-service work and are not publically available at this time.

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:
The specialties requested, and the RUC agreed, that CPT code 45338 should have a note in the RUC database that states this code should not be used to validate for physician work. The specialties stated that an intra-service time of 15 minutes underrepresents the physician work involved in the snare technique, especially compared to other endoscopic snare codes.

Colonoscopy (Tab 10)
Joel Brill, MD (AGA); Shivan Mehta, MD (AGA); Nicholas Nickl, MD (ASGE); Edward Bentley,MD (ASGE); R. Bruce Cameron, MD (ACG); Guy Orangio, MD (ASCRS); Charles Mabry, MD (ACS); Donald Selzer, MD (SAGES)
Facilitation Committee #1

Several specific CPT codes identified by CMS through the MPC List screen were scheduled for review at the September 2011 RUC meeting. The RUC review of the codes led to significant concerns with the survey data, and in some cases, coding and payment policy for the individual codes. The specialty societies representing gastroenterology indicated that appropriate surveys could not be conducted until after the specialty societies had an opportunity to clarify the coding and update the descriptors via the CPT Editorial Panel Process. The specialty societies worked with the CPT Editorial Panel and CMS to resolve this coding and payment policy question as it relates to over 100 GI endoscopy services.

In the CPT 2014 cycle, the RUC reviewed all the esophagoscopy, EGD and ERCP families of codes. For the CPT 2015 cycle, the RUC reviewed the illeoscopy, pouchoscopy and flexible sigmoidoscopy services in October 2013 and reviewed colonoscopy and colonoscopy through the stoma procedures in January 2014. In November, 2013, as part of the 2014 Medicare Final Rule, CMS released their work value recommendations on the three families reviewed for the CPT 2014 cycle. It was noted that while CMS disagreed with a majority of the RUC recommendations, the agency seemed to agree that the incremental methodology was the best approach to use in valuing these codes. However, the RUC agreed that CMS often used inappropriate assumptions regarding physician work and intensity and thus offered increments for procedures not in accordance with the appropriate clinical utility either within the immediate family or within the larger code family. Therefore, as was done in the previous set of codes, the RUC continued to use the incremental methodology as its primary approach to valuing the additional physician work above the base diagnostic procedure. The RUC noted that this methodology was necessary for three reasons. First, given that an entire genre of services is being reviewed, relativity amongst the family is critical. The

potential for rank order anomalies is high considering the large amount of codes reviewed in succession. Second, CMS (then HCFA) used the incremental approach in their initial valuation of these services in 1992 and 1993. According to CMS commentary in the Federal Register for those years, the agency established a hierarchy of work from the least to the most difficult endoscopic procedure. Following this, fixed increments were added to the base procedure. Therefore, the RUC determined that these new codes should continue to be valued the same way endoscopic services were initially valued at the creation of the RBRVS. Finally, the RUC has established valuation of physician work through incremental intra-service work as an approved, viable alternate methodology. In fact, endoscopy is listed as an example of this methodology in the RUC's instructions for specialty societies developing work value recommendations.

The RUC and the specialty societies explicitly addressed the perception that there is a body of peer-reviewed literature which states that diagnostic colonoscopies take 15 minutes of time to perform. When valuing procedures at the RUC, the Committee views the RUC survey as the gold standard for validating physician time and valuing physician work. So, in order to validate a RUC survey, one would need to produce another equally valid survey, which would measure time and intensity in a similar way. In order to ensure the specialties' survey meets the exacting standards that are expected of a RUC survey, the RUC reviewed two pieces of information.

First, a demographic breakout of the survey respondents was reviewed to ensure that the survey population closely matches the population of real world patients receiving diagnostic colonoscopies. The specialty societies, after the survey was completed, went back to the survey respondents and collected additional demographic data, not typically collected as part of the standard RUC survey. For instance, 94% of the survey respondents indicated that they perform the majority of colonoscopy procedures in a facility setting, while 94% of Medicare patients receive a diagnostic colonoscopy in a facility. Also, the specialty societies also demonstrated that the RUC survey was representative in terms of both practice type, with a mix of single specialty groups, multi-specialty groups and Medical School Faculty Practice plans, and geographic practice setting, with an even share of respondents practicing in suburban and urban locations. Finally, 89% of the survey respondents indicated that they typically work out of 1 room simultaneously. The RUC recognizes that there would be efficiencies gained if a physician is working out of 2 rooms, however that is not typical. Given this large, varied data sample, the RUC agreed with the specialty society that the survey data accurately represents the typical scenario in which a physician would perform a diagnostic colonoscopy in the U.S.

Second, to specifically address the question of peer-reviewed literature, the specialties provided a table of fifteen articles published over the last decade or so in which there is some reference to colonoscopy procedure time. Importantly, none of these studies were done with the purpose of obtaining colonoscopy procedure time. Each study had some other goal (e.g. withdrawal time from adenoma detection rate, pain perception, etc). As a result, the authors chose their patient population to achieve the primary study question involved. In addition, many of the studies are single center studies, done in the Ambulatory Surgical Center (ASC), which do not represent much of the variety seen in the typical scenario.

Specifically, the specialties addressed the most well-known of these studies, the Robert Barclay study in the New England Journal of Medicine (NEJM) (*N Engl J Med*

2006;355:2533-41). This study was performed in a single center ASC. The methodology for measuring the endoscope time was reasonably precise but may not have included washing time or suctioning time. In addition, there was an insurance status criterion which was applied for the inclusion of patients in this study which mitigated a truly random population. Therefore, this study is not truly generalizable since these patients are the most straightforward patients that go to the ASC, are healthy and complete their prep. The specialties noted that even after noting these flaws in the data throughout, the listed studies tend to center around the 25 minutes of intra-service time, the median survey time for the diagnostic colonoscopy code 45378. Furthermore, the specialty societies noted a study that was submitted to the journal *Gastrointestinal Endoscopy*, which reports a large study of 522 colonoscopy procedure performed at the Mayo Clinic, which show a mean total procedure time of 23.2 minutes.

Finally, the specialties discussed that far from having the physician work intensity of these services decrease over the years, in some ways colonoscopies are more intense today. In current practice there is an enhanced appreciation for flat adenomas, particularly in the right side of the colon. These were not known to exist or be nearly as prevalent during previous valuations. The adenomas are more difficult to identify because they aren't raised like ordinary polyps. To identify, the physician must look at the texture of the colon which requires greater scrutiny and washing to perform. The specialties explained that while these arguments are not made to provide compelling evidence, the work intensity has at the very least not gone down in comparison to both previous valuations and other services across the RBRVS.

45378 ***Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed, (separate procedure)***
The RUC reviewed the survey results of 165 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 27 minutes, intra-service time of 25 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 1B Facility straightforward patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that they were overvalued, with a 25th percentile work RVU of 3.60. The RUC noted that even with the shift of moderate sedation from the intra-service time, in the previous valuation, to the pre-service, the current survey still shows an 8 minute drop in total time, 75 minutes to 67 minutes. Therefore, the RUC reviewed the Key Reference Service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that while the reference code has 5 additional minutes of intra-service time, 30 minutes compared to 25 minutes, 45378 is a slightly more intense procedure and should be valued identically to 31625. To further justify a work RVU of 3.36 for CPT code 45378, the RUC compared the surveyed code to CPT code 58555 *Hysteroscopy, diagnostic (separate procedure)* (work RVU= 3.33) and agreed that both services should be valued almost identically given identical intra-service times and analogous work intensity. Finally, the RUC reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed,* open (work RVU= 3.29, intra time= 20 minutes) and agreed that with comparable physician work and similar total time, this reference

code offers and an accurate comparison to the recommended value. **The RUC recommends a work RVU of 3.36 for CPT code 45378.**

45379 ***Colonoscopy, flexible; with removal of foreign body***
The RUC reviewed the survey results of 104 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 35 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the current work RVU of 4.68, in between the median and 25th percentile, is too high considering the drop in total time from the current time to the surveyed time. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 1.01 in the upper GI endoscopic family of services for the additional work of removing a foreign body over the base diagnostic procedure. Therefore, the RUC added the approved 1.01 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 4.37 for 45379, which is lower than the current value.

To justify a work RVU of 4.37, the RUC compared the surveyed code to MPC code 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= 4.71) and noted that while the reference code has 5 less minutes of intra-service time, 30 minutes compared to 35 minutes, 37191 is a more intense procedure and should be valued higher than 45379. In addition, the RUC also reviewed CPT codes 31629 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (work RVU= 4.09, intra time= 30 minutes) and 35476 *Transluminal balloon angioplasty, percutaneous; venous* (work RVU= 5.10, intra time= 35 minutes) and agreed that with comparable physician work and similar total times, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 4.37 for CPT code 45379.**

45380 ***Colonoscopy, flexible; with biopsy, single or multiple***
The RUC reviewed the survey results of 152 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 27 minutes, intra-service time of 28 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 1B Facility straightforward patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the current work RVU of 4.43, the survey median, is too high considering the drop in total time from the current time to the surveyed time. The RUC agreed that the appropriate

methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 0.30 in the upper GI endoscopic family of services for the additional work of performing a biopsy over the base diagnostic procedure. Therefore, the RUC added the approved 0.30 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 3.66 for 45380, which is lower than the current value.

To justify a work RVU of 3.66, the RUC compared the surveyed code to MPC code 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands* (work RVU= 3.50) and noted that while the reference code has 2 additional minutes of intra-service time, 45380 is a more intense procedure and is correctly valued higher than this MPC code. In addition, the RUC reviewed CPT codes 57461 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix* (work RVU= 3.43, intra time= 28 minutes) and 31629 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (work RVU= 4.09, intra time= 40 minutes) and agreed that with comparable physician work and similar total times, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 3.66 for CPT code 45380.**

45381 ***Colonoscopy, flexible; with directed submucosal injection(s), any substance***
The RUC reviewed the survey results of 123 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 27 minutes, intra-service time of 28 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 1B Facility straightforward patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the respondents overestimated the work of this procedure, with a 25th percentile value of 3.95. Given the total time reduction from the current time to the newly surveyed time, the RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 0.31 in the upper GI endoscopic family of services for the additional work of performing a submucosal injection over the base diagnostic procedure. Therefore, the RUC added the approved 0.31 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 3.67 for 45381, which is lower than the current value.

To justify a work RVU of 3.67, the RUC compared the surveyed code to MPC code 52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy* (work RVU= 4.05) and agreed that since the reference code has slightly higher intra-service time, 30 minutes compared to 28 minutes, and is a slightly more intense procedure, 52224 is valued appropriately higher than CPT code 45381. In addition, the RUC reviewed CPT codes 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU= 3.12, intra time= 30 minutes) and 15277 *Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm;*

first 100 sq cm wound surface area, or 1% of body area of infants and children (work RVU= 4.00, intra time= 25 minutes) and agreed that with comparable physician work and similar total times, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 3.67 for CPT code 45381.**

45382 ***Colonoscopy, flexible; with control of bleeding, any method***
The RUC reviewed the survey results of 120 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 41 minutes, intra-service time of 40 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the appropriate value for 45382 should be in between the median (5.50) and 25th percentile (4.50) work values. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 1.40 in the colonoscopy through stoma family of services for the additional work of controlling bleeding over the base diagnostic procedure. Therefore, the RUC added the approved 1.40 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 4.76 for 45382, which is lower than the current value.

To justify a work RVU of 4.76, the RUC compared the surveyed code to CPT code 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C* (work RVU= 4.74) and noted that both services have identical intra-service time, 40 minutes, and comparable physician work. Therefore, the RUC agreed that both services should be valued almost identically. In addition, the RUC reviewed CPT codes 49406 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous* (work RVU= 4.25, intra time= 40 minutes) and 93724 *Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)* (work RVU= 4.88, intra time= 40 minutes) and agreed that with comparable physician work and identical intra-service times, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 4.76 for CPT code 45382.**

4538X1 ***Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)***
The RUC reviewed the survey results of 76 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 35 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the appropriate value for 4538X1 should be in between the median (5.50) and 25th percentile (4.50) work values. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 1.62 in the colonoscopy through stoma family of services for the additional work of performing ablation of a tumor with pre/post dilation and guide wire passage over the base diagnostic procedure. Therefore, the RUC added the approved 1.62 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 4.98 for 4538X1.

To justify a work RVU of 4.98, the RUC compared the surveyed code to CPT code 52276 *Cystourethroscopy with direct vision internal urethrotomy* (work RVU= 4.99) and agreed that since both codes have identical, intra-service time, 35 minutes, and comparable physician work, the two codes should be valued almost identically. In addition, the RUC reviewed CPT codes 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C* (work RVU= 4.74, intra time= 40 minutes) and 35476 *Transluminal balloon angioplasty, percutaneous; venous* (work RVU= 5.10, intra time= 35 minutes) and agreed that with comparable physician work and similar total times, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 4.98 for CPT code 4538X1.**

45384 ***Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery***

The RUC reviewed the survey results of 101 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 27 minutes, intra-service time of 28 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 1B Facility straightforward patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the respondents overestimated the work of this procedure, with a median value of 4.50. Given the intra-service time reduction from the current time to the newly surveyed time, the RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 0.81 in the upper GI endoscopic family of services for the additional work of removing a tumor by hot biopsy over the base diagnostic procedure. Therefore, the RUC added the approved 0.81 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 4.17 for 45384, which is lower than the current value.

To justify a work RVU of 4.17, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and noted that although the reference code has 2 additional minutes of intra-service time, CPT code 45384 is a more intense procedure and should be valued identically to code 32550. In addition , the RUC reviewed CPT codes 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal* (work RVU= 4.00, intra time= 30 minutes) and 52275 *Cystourethroscopy, with internal urethrotomy; male* (work RVU= 4.69, intra time= 30 minutes) and agreed that with comparable physician work and similar total

times, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 4.17 for CPT code 45384.**

45385 ***Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique***
The RUC reviewed the survey results of 145 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 30 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the appropriate value for 45385 should be in between the median (5.25) and 25th percentile (4.38) work values. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 1.31 in the upper GI endoscopic family of services for the additional work of removing a tumor by snare over the base diagnostic procedure. Therefore, the RUC added the approved 1.31 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 4.67 for 45385, which is lower than the current value.

To justify a work RVU of 4.67, the RUC compared the surveyed code to MPC code 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= 4.71) and determined that while both service have identical intra-service time, 30 minutes, code 45385 is a more intense procedure and should be valued slightly higher than 37191. In addition, the RUC reviewed CPT codes 52234 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)* (work RVU= 4.62, intra time= 30 minutes) and 37213 *Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed* (work RVU= 5.00, intra time= 33 minutes) and agreed that with comparable physician work and similar total times, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 4.67 for CPT code 45385.**

45386 ***Colonoscopy, flexible; with transendoscopic balloon dilation***
The RUC reviewed the survey results of 80 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 38 minutes, intra-service time of 35 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the respondents overestimated the physician work involved in this procedure with a 25th percentile work RVU of 4.55. To account for the drop in total time from the current time to the survey, the RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 0.51 in the upper GI endoscopic family of services for the additional work of balloon dilation less than 30 mm over the base diagnostic procedure. Therefore, the RUC added the approved 0.51 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 3.87 for 45386, which is lower than the current value.

To justify a work RVU of 3.87, the RUC compared the surveyed code to CPT code 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= 3.82) and agreed that while the reference code has 5 additional minutes of intra-service time, code 45386 is a more intense procedure and should thus be valued slightly higher than 49411. In addition, the RUC reviewed MPC code 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands* (work RVU= 3.50, intra time= 30 minutes) and CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous* (work RVU= 4.21, intra time= 40 minutes) and agreed that with comparable physician work and similar total times, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 3.87 for CPT code 45386.**

4538X2 ***Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)***
The RUC reviewed the survey results of 64 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 41 minutes, intra-service time of 45 minutes and post-service time of 17 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the appropriate value for 4538X2 should be in between the median (5.99) and 25th percentile (5.00) work values. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 2.14 in the upper GI endoscopic family of services for the additional work of stent placement over the base diagnostic procedure. Therefore, the RUC added the approved 2.14 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 5.50 for 4538X2.

To justify a work RVU of 5.50, the RUC compared the surveyed code to MPC code 52235 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery)*

and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm) (work RVU= 5.44) and agreed that while both services have identical intra-service time, 45 minutes, 4538X2 has slightly more total time and should thus be valued slightly higher. In addition, the RUC reviewed CPT codes 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 5.35, intra time= 45 minutes) and 93458*Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed* (work RVU= 5.85, intra time= 45 minutes) and agreed that with comparable physician work and identical intra-service time, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 5.50 for CPT code 4538X2.**

45391 ***Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures***

The RUC reviewed the survey results of 37 gastroenterologists and recommends the following physician time components: pre-service time of 41 minutes, intra-service time of 45 minutes and post-service time of 20 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the respondents underestimated (median work RVU= 4.75) the physician work involved in this service. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 1.59 in the upper GI endoscopic family of services for the additional work of performing an endoscopic ultrasound over the base diagnostic procedure. Therefore, the RUC added the approved 1.59 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 4.95 for 45391, which is lower than the current value.

To justify a work RVU of 4.95, the RUC compared the surveyed code to CPT code 52315 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated* (work RVU= 5.20) and noted that while both services have identical intra-service time, 45 minutes, the reference code is a more intense procedure and should be valued higher than code 45391. In addition, the RUC reviewed CPT codes 93724 *Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)* (work RVU= 4.88, intra time= 40 minutes) and 58562 *Hysteroscopy, surgical; with removal of impacted foreign body* (work RVU= 5.20, intra time= 40 minutes) and agreed that with comparable physician work and similar total times, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 4.95 for CPT code 45391.**

45392 ***Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures***
The RUC reviewed the survey results of 35 gastroenterologists and recommends the following physician time components: pre-service time of 41 minutes, intra-service time of 60 minutes and post-service time of 20 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the respondents underestimated (median work RVU= 5.50) the physician work involved in this service. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 2.24 in the upper GI endoscopic family of services for the additional work of performing ultrasound guidance with fine needle aspiration over the base diagnostic procedure. Therefore, the RUC added the approved 2.24 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 5.60 for 45392, which is lower than the current value.

To justify a work RVU of 5.60, the RUC compared the surveyed code to CPT code 50382 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation* (work RVU= 5.50) and noted that since both codes have identical intra-service time, 60 minutes, and analogous total time, both services should be valued similarly. In addition, the RUC reviewed CPT codes *52001Cystourethroscopy with irrigation and evacuation of multiple obstructing clots* (work RVU= 5.44, intra time= 60 minutes) and 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, radiofrequency, unilateral* (work RVU= 5.68, intra time= 60 minutes) and agreed that with comparable physician work and identical intra-service time, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 5.60 for CPT code 45392.**

4538X3 ***Colonoscopy, flexible; with endoscopic mucosal resection***
The RUC reviewed the survey results of 74 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 45 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the appropriate value for 4538X3 should be in between the median (6.61) and 25th percentile (5.35) work values. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work

RVU of 2.99 in the upper GI endoscopic family of services for the additional work of performing endoscopic mucosal resection over the base diagnostic procedure. Therefore, the RUC added the approved 2.99 work RVUs to CPT code 45378 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 6.35 for 4538X3.

To justify a work RVU of 6.35, the RUC compared the surveyed code to MPC code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU= 6.75) and noted that while both services have identical intra-service time, 45 minutes, the reference code has more total time and should thus be valued higher than 4538X3. In addition, the RUC reviewed CPT codes 93453 *Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed* (work RVU= 6.24, intra time= 45 minutes) and 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= 7.35, intra time= 45 minutes) and agreed that with comparable physician work and identical intra-service time, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 6.35 for CPT code 4538X3.**

4538X4 ***Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed***
The RUC reviewed the survey results of 98 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 41 minutes, intra-service time of 40 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the respondents' estimated physician work values and agreed that the appropriate value for 4538X4 should be in between the median (5.50) and 25th percentile (4.50) work values. The RUC agreed that the appropriate methodology for valuing this service is to use the RUC established increment. The RUC previously established a work RVU of 1.42 in the colonoscopy through stoma family of services for the additional work of performing decompression over the base diagnostic procedure. Therefore, the RUC added the approved 1.42 work RVUs to CPT code 4538X4 (RUC recommended work RVU = 3.36) to arrive at a work RVU of 4.78 for 4538X4.

To justify a work RVU of 4.78, the RUC compared the surveyed code to CPT code 49406 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous* (work RVU= 4.25) and agreed that while both codes have identical intra-service time, 40 minutes, and analogous total time, 4538X4 is a more intense procedure and should be valued higher than the reference code. In addition, the RUC reviewed MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU= 3.80, intra time= 40 minutes) and CPT code 93455 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free

arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography (work RVU= 5.54, intra time= 40 minutes) and agreed that with comparable physician work and identical intra-service time, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 4.78 for CPT code 4538X4.**

4538X5 ***Colonoscopy, flexible; with banding, (eg, hemorrhoids)***
The RUC reviewed the survey results of 65 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 30 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and procedure with sedation was appropriate with two additional minutes for left lateral decubitus positioning of the patient, and to position the endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC noted that since this service does not have an equivalent RUC approved increment from any previous family, the survey respondents' 25th percentile, a work RVU of 4.30, is an appropriate value for 4538X5. To justify a work RVU of 4.30, the RUC compared the surveyed code to CPT code 52234 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)* (work RVU= 4.62) and noted that while both services have identical intra-service time, 30 minutes, the reference code is a more intense procedure and should be valued higher than 4538X5. In addition, the RUC reviewed CPT codes 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17, intra time= 30 minutes) and 52275 *Cystourethroscopy, with internal urethrotomy; male* (work RVU= 4.69, intra time= 30 minutes) and agreed that with comparable physician work and identical intra-service time, these reference codes offer appropriate brackets for the recommended value. **The RUC recommends a work RVU of 4.30 for CPT code 4538X5.**

G0105 ***Colorectal cancer screening; colonoscopy on individual at high risk***
G0121 ***Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk***
The above HCPCS Level II G codes were created in 1998 by CMS as a mechanism to identify a screening service for which there was a newly approved Medicare benefit, and to ensure that frequency limits could be monitored during claims adjudication. Each G-code has a matched Category I CPT code with exactly the same physician work, same practice expense details, and same payment. CMS and other third-party payors have maintained throughout the history of these codes that there is no difference in physician work between these codes are their corresponding CPT codes. The RUC agreed with the specialty societies that colonoscopy, as defined by CPT, is the same procedure whether it is performed on a patient with a family history of cancer (ie, high risk); on an asymptomatic patient as a preventative service (ie, not meeting criteria for high risk); or on a patient with a prior history of polyp removal. For each of these patients, the same colonoscopy procedure is performed by the provider, as clearly defined in the revised CPT guidelines. **Therefore, the RUC recommends a work RVU of 3.36 for G0105 and G0121, a direct crosswalk to CPT code 45378.**

Practice Expense:
The Practice Expense Subcommittee reviewed the direct practice expense inputs for the colonoscopy services and noted that these services mostly crosswalk from the flexible sigmoidoscopy codes approved for 2014. In general, the total clinical staff times were slightly lower than the current inputs. The largest change was the addition of 30 minutes for staff to clean the scope. There were several modifications to supplies for a small subset of codes to match refinements made to the flexible sigmoidoscopy codes approved in the previous year. Finally, there was the addition of a new supply, hemorrhoidal banding system, for CPT code 4538X5. The RUC approved the revised PE spreadsheet as modified 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.

The six presenting specialty societies formally requested attribution in the RUC meeting minutes that they are not in agreement with the work values as approved by the RUC for the Colonoscopy family of services.

Myelography (Tab 11)
Ezequiel Silva, III, MD (ACR); Joshua Hirsch, MD (ASNR)

In October 2013, the CPT Editorial Panel established four Category I codes to report the injection of contrast myelography with radiological S&I, image guidance; editorially revised exclusionary parenthetical notes to include the new services. The RUC will also review CPT code 62284 *Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)* to ensure relativity.

The specialty societies requested withdrawal of the Myelography family from review at the January 2014 RUC meeting. At the time of survey, the reference service list in the myelography survey instrument mistakenly included a CPT code that was pending CMS review, and may undergo refinement in 2014. As a result, the survey instrument was unintentionally misleading. Since the code in question was chosen as the key reference code for four of the five surveyed myelography codes, the RUC determined that the data was invalid. **The RUC recommends that these services be postponed and surveyed for physician work and develop direct practice expense inputs for the April 2014 RUC meeting.**

Aqueous Shunt (Tab 12)
Stephen A. Kamenetzky, M.D. (AAO); David B. Glasser (AAO); George Reiss, M.D. (AAO)

CPT code 66180 was identified through the Harvard-Valued Annual Allowed Charges ≥ $10 million screen. In January 2013, the RUC recommended survey of physician work and review of practice expense for this family of services. The direct practice expense inputs were reviewed at the January 2013 meeting. However, the review of physician work was postponed for review at the April 2013 RUC meeting in order to assure the surveyed post-operative visits were calculated correctly. In April 2013, the American Academy of Ophthalmology noted that based on data from the last meeting the specialty society was informed that 66180 is typically reported (73%) with *67255 Scleral reinforcement (separate procedure); with graft* and it appears that these services should

be surveyed as a bundled code. The specialty society requested that 66180 and 66185 be referred to CPT to create codes to describe with and without patch. The specialty society also noted that they will survey 67255 with this family of services.

Prior to valuing this family of services, the RUC discussed the relative high number of post-operative visits for these procedures. For the two codes describing placement of an external drainage system with and without graft (66179X1 and 66180) the survey median post-operative visits contained three 99213 Evaluation and Management codes and five 99214 Evaluation and Management codes. For the two codes describing revision of the aqueous shunt with and without graft (66184X1 and 66185) the survey median post-operative visits contained three 99213 Evaluation and Management codes and four 99214 Evaluation and Management codes. The specialty society explained, and the RUC agreed, that these levels of visits are appropriate due to the intense post-operative management intrinsic to the care of patients with severe glaucoma. The small internal diameter of the shunt tubing makes obstruction of the internal opening in the anterior chamber a frequent complication. This is treated in the office with laser or other techniques as part of the global surgical package during one of the post-operative visits. Furthermore, there is a consistent need to monitor the pressure. Typically patients will not show outward signs that the pressure is either too high or too low, requiring the physician to inspect in person the patient's eye. It is also typical that during these follow-up visits, medications will have to be adjusted due to pressure being too high or too low, thus necessitating further follow-up to ensure the medication is working correctly. Another unique feature of these services is that patients have often had multiple prior procedures and there is a great deal of scar tissue which can make it necessary for the physician to have to put in sutures in the office. Finally, the specialties noted that while the 99213 visits are primarily for managing pressure, the higher level 99214 visits are justified for the more intense follow-up work related to the obstruction of the internal opening and the potential need for additional suturing.

66179X1 ***Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft***
The RUC reviewed the results from 38 Ophthalmologists and agreed with the specialty society on the following physician time components: pre-service time of 25 minutes, intra-service time of 55 minutes and post-service time of 10 minutes. The RUC also agreed with the following post-operative visits: three 99212 visits, five 99213 visits and one-half day discharge (99238).

The RUC discussed the reduction in intra-service time from the current Harvard time, 84 minutes, to the survey median of 55 minutes. When the initial Harvard valuation took place, these shunts were new devices. They were used primarily in patients who had blind, painful eyes that had not responded to conventional treatment, or for patients that had complex ocular conditions with a poor prognosis with other methods. Now, many of the patients have advanced glaucoma, but with an excellent chance for preservation of functional vision. Today the goal of treatment is to lower pressure in order to maintain vision rather than relieve pain. This increases the physician work by increasing the iatrogenic risk as well as mental effort and judgment during the intra-service period and during the follow-up period. The current shunts and the external reservoirs also are more complex with extension devices and flow restriction modifications that improve results but increase technical challenges both intra-operatively and in the post-operative period. With this in mind, the RUC reviewed the survey respondents' estimated physician work RVUs and agreed that the 25th percentile, a work RVU of 14.00, is an accurate value for

CPT code 66179X1. The RUC maintained that while the work RVU should be reduced from its current value of 16.30, the work RVU should not be reduced commensurate to the reduction in the previous Harvard intra-service time derived over 20 years ago.

To justify a work RVU of 14.00, the RUC compared the surveyed code to the Key Reference Service 65756 *Keratoplasty (corneal transplant);* endothelial (work RVU= 16.84) and noted that while the reference service has less total time, due to less post-operative visits, it has more intra-service time compared to 66179X1, 60 minutes and 55 minutes, respectively, and is a more intense procedure because keratoplasty reflects intraocular work. Therefore, the surveyed code is appropriately valued less than this reference code. The RUC also reviewed CPT code 45160 *Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach* (work RVU= 16.33) and agreed that since this reference code again has 5 additional minutes of intra-service time and greater total time, 66179X1 is appropriately valued less than code 45160. **The RUC recommends a work RVU of 14.00 for CPT code 66179X1.**

66180 ***Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft***

The RUC reviewed the results from 45 Ophthalmologists and agreed with the specialty on the following physician time components: pre-service time of 25 minutes, intra-service time of 60 minutes and post-service time of 10 minutes. The RUC also agreed with the following post-operative visits: three 99212 visits, five 99213 visits and one half-day discharge (99238).

The RUC discussed the reduction in intra-service time from the current Harvard time, 84 minutes, to the survey median of 60 minutes. When the initial Harvard valuation took place, these shunts were new devices. They were used primarily in patients who had blind, painful eyes that had not responded to conventional treatment, or for eyes that had complex ocular conditions with a poor prognosis with other methods. Now many of the patients have advanced glaucoma, but with an excellent chance for preservation of functional vision. Today the goal of treatment is to lower pressure in order to maintain vision rather than relieve pain. This increases the physician work by increasing the iatrogenic risk as well as mental effort and judgment during the intra-service period and during the follow-up period. The current shunts and the external reservoirs also are more complex with extension devices and flow restriction modifications that improve results but increase technical challenges both intra-operatively and in the post-operative period. With this in mind, the RUC reviewed the survey respondents' estimated physician work RVUs and agreed that the 25th percentile, a work RVU of 15.00, is an accurate value for CPT code 66180. The RUC agreed that a 1.00 work RVU increase for the additional 5 minutes of intra-service work above the based procedure (66179X1) is appropriate to account for the physician work of placing a scleral patch.

To justify a work RVU of 15.00, the RUC compared the surveyed code to the Key Reference Service 65756 *Keratoplasty (corneal transplant);* endothelial (work RVU= 16.84) and noted that while both codes have identical intra-service time, 60 minutes, the reference code should still be valued higher than 66180 because keratoplasty reflects intraocular work, which is more intense. Therefore, the surveyed code is appropriately valued less than this reference code. The RUC also reviewed CPT code 58260 *Vaginal hysterectomy, for uterus 250 g or less* (work RVU= 14.15) and agreed that while both services have identical intra-service time, 66180 is a more intense service and should be

valued slightly higher than the reference code. **The RUC recommends a work RVU of 15.00 for CPT code 66180.**

66183 ***Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach***
The RUC reviewed their previous recommendation for this service from the April 2013 meeting and maintained that the recommended work RVU of 13.20 for CPT code 66183, as agreed to by CMS as well, is correct. Below is the April 2013 RUC Recommendation as reaffirmed by the Committee in January 2014:

At the April 2013 RUC meeting, it was confirmed that post-operative visits were accurately calculated and that 70% of the physician work is captured in the post-operative visits. The RUC noted that patients with glaucoma undergoing this procedure require intense care for the entire 090-day global period, above any other ophthalmological service. The patient is in danger of further visual loss due to the intraocular pressure which the physician must frequently monitor. In addition, this procedure creates a fistula which must remain open after healing is complete. Closure of the fistula can occur throughout the entire 090-day global period and requires constant management of the patient. The RUC had a robust discussion regarding number of post-operative office visits and agreed that 8 visits: (3) 99212 and (5) 99213, the survey mode, rather than 9 visits, the survey median: (3) 99212 and (6) 99213 with the reduction of one office visit is more appropriate. To validate the number of visits, the RUC compared 66183 to CPT code 66174 *Transluminal dilation of aqueous outflow canal; without retention of device or stent* (work RVU=12.85) which was reviewed at the April 2010 RUC meeting and include 6 post-operative visits, (2) 99212 and (4) 99213. The RUC agreed that 66183 is a more intense procedure than 66174 and requires additional monitoring.

The RUC reviewed the survey results from 56 ophthalmologists and determined that a work RVU of 13.20, the survey 25th percentile is appropriate. The RUC compared 66183 to key reference code 65756 *Keratoplasty (corneal transplant); endothelial* (work RVU=16.84) and agreed that since 65756 requires 15 minutes more intra-service time, it should be valued higher. The RUC also reviewed 65850 *Trabeculotomy ab externo* (work RVU=11.39) and determined that the 66183 requires less intra-service time but is more intense and complex to perform. **The RUC recommends a work RVU of 13.20, the survey 25th percentile for CPT code 66183.**

66184X1 ***Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft***
The RUC reviewed the results from 34 Ophthalmologists and agreed with the specialty on the following physician time components: pre-service time of 25 minutes, intra-service time of 60 minutes and post-service time of 10 minutes. The RUC also agreed with the following post-operative visits: three 99212 visits, four 99213 visits and one-half day discharge (99238).

The RUC reviewed the respondents' estimated physician work values and agreed with the specialty that the values were overestimated, with a 25th percentile work RVU of 12.25. The RUC determined the work values were too high because half of the respondents chose a Key Reference Service with 50 percent more intra-service time than the median time for code 66184X1. The RUC also noted that the current Harvard intra-service time

of 60 minutes directly matches the median intra time from the survey. Therefore, the current work RVU of 9.58 is the appropriate value for 66184X1.

To justify a work RVU of 9.58, the RUC compared the surveyed code to CPT code 67966 *Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin* (work RVU= 8.97) and agreed that while both codes have 60 minutes of intra-service time, the surveyed code has higher total time in the post-operative global period and is appropriately valued higher than the reference code. In addition, the RUC reviewed CPT codes 24685 *Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed* (work RVU= 8.37, intra time= 60 minutes) and 44950 *Appendectomy* (work RVU= 10.60, intra time= 60 minutes) and agreed that since both codes have identical intra-service time compared to 66184X1 and similar total time, they provide appropriate brackets above and below the recommended work value. **The RUC recommends a work RVU of 9.58 for CPT code 66184X1.**

66185 ***Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft***
The RUC reviewed the results from 36 Ophthalmologists and agreed with the specialty on the following physician time components: pre-service time of 25 minutes, intra-service time of 65 minutes and post-service time of 10 minutes. The RUC also agreed with the following post-operative visits: three 99212 visits, four 99213 visits and one-half day discharge (99238). The RUC noted that the survey's median intra-service time, 60 minutes, was identical to the intra time of the without graft code, 666184X1. The RUC agreed with the specialty that there is additional time spent adding the patch from the base procedure. Therefore, the difference between the initial aqueous shunt codes without (66179X1) and with graft (66180), 5 minutes, was added to the revision of shunt without graft code (66184X1) to arrive at an intra-service time of 65 minutes for 66185.

The RUC reviewed the respondents' estimated physician work values and agreed with the specialty that the values were overestimated, with a 25th percentile work RVU of 14.88. The RUC determined that the work values were too high because half of the respondents chose a Key Reference Service with nearly 50 percent more intra-service time than the median time for code 66185. To determine an appropriate work value, the RUC reviewed the increment of 1.00 work RVU for 5 additional minutes of intra-service between the initial aqueous shunt without and with graft procedures (66179X1 and 66180) and agreed that this same increment should be applied to the revision codes. Therefore, the RUC added 1.00 work RVU to the RUC recommended work RVU of 9.58 for CPT code 66184X1 to arrive at a work RVU of 10.58.

To justify a work RVU of 10.58, the RUC compared the surveyed code to CPT codes 23430 *Tenodesis of long tendon of biceps* (work RVU= 10.17, intra time= 60 minutes) and 57285 *Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach* (work RVU= 11.60, intra time= 60 minutes) and agreed that since both these reference codes have similar intra-service times and total times compared to 66185, they provide appropriate brackets above and below the recommended work RVU of 10.58 for the surveyed code. **The RUC recommends a work RVU of 10.58 for CPT code 66185.**

67255 ***Scleral reinforcement (separate procedure); with graft***

The RUC reviewed the results from 15 Ophthalmologists and agreed with the specialty on the following physician time components: pre-service time of 25 minutes, intra-service time of 45 minutes and post-service time of 10 minutes. The RUC also agreed with the following post-operative visits: three 99212 visits, three 99213 visits and a half-day discharge management code 99238.

The RUC discussed the reduction in intra-service time from the current Harvard time, 89 minutes, to the survey median of 45 minutes. There are several problems with directly comparing the current time to the survey. First, there has been a dramatic change in the patient population since the Harvard valuation. Currently, patients receiving this low volume service will be suffering from rheumatoid melts with good visual potential, but at substantial risk of going blind or perforating and losing the eye. In the past, these were patients having reinforcement for thin sclera in a non-inflamed eye or for tectonic support in an eye that was already blind. The RUC agreed that the survey data indicating three 99212 and three 99213 office visits was accurate. Because of the gravity of the scleral melt, more postoperative examinations are needed for these patients to assess healing, confirm integrity of the posterior segment and graft, and monitor intraocular pressure and the response to anti-inflammatory medications. Second, since this is a low volume service the Harvard time is likely to have been derived and not surveyed, which may have led to higher time than was typical when it was valued over 20 years ago. With this in mind, the RUC reviewed the survey respondents' estimated physician work RVUs and agreed that the respondents overvalued the service, with a 25th percentile work RVU of 11.10. Therefore, the RUC agreed that the current work RVU of 10.17 is an accurate value for CPT code 67255.

To justify a work RVU of 10.17, the RUC compared the surveyed code to CPT codes 27829 *Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed* (work RVU= 8.80, intra time= 45 minutes) and 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)* (work RVU= 11.30, intra time= 45 minutes) and agreed that since both these reference codes have identical intra-service times and analogous total times compared to 67255, they provide appropriate brackets above and below the recommended work RVU of 10.17 for the surveyed code. **The RUC recommends a work RVU of 10.17 for CPT code 67255.**

Practice Expense:
The RUC reviewed the standard 090-day global direct practice expense inputs and noted the only difference from the current inputs is the increase in post-operative visits, thus increasing the post-operative clinical labor time. The RUC approved the direct PE inputs as presented by the specialty society and accepted 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.

RUC Database Flag:
Do to the low response rate and low respondent median service performance rate, CPT code 67255 should be flagged in the RUC database as not to be used to validate for physician work.

Breast Ultrasound (Tab 13)
Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR)

CPT code 76645 *Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation* was one of seven codes describing ultrasound of the body identified by the CMS/Other Utilization over 500,000 screen. The six other ultrasound services were surveyed and reviewed by the RUC at the October 2013 meeting. CPT code 76645 was brought to the CPT Editorial Panel for clarification. In October 2013, the CPT Editorial Panel deleted code 76645 and established two codes to report limited and complete breast ultrasound procedures.

The specialty societies indicated, and the RUC agreed, that there is compelling evidence that the physician work has changed for these services based on an original flawed methodology, as well as a change in technology and patient population for CPT code 76645. The current work RVU and physician time for 76645 is based on a CMS crosswalk, not a survey. Technology has changed, specifically with the increased utilization of higher frequency transducers, improved resolution of transducers and more sophisticated ultrasound algorithms, physicians are better able to evaluate cysts and delineate which ones require aspiration. Additionally, physicians are better able to evaluate solid nodules, including evaluation of internal architecture, edge morphology, and vascularity. They are able to assess for the presence of satellite lesions and are able to find very small lesions, previously undetectable by ultrasound. Ultrasound is now capable of evaluating subtle abnormalities seen on other imaging modalities such as architectural distortion seen on mammography or suspicious enhancement seen on MRI. The physician work and intensity level has increased because of the aforementioned reasons and need to make decisions regarding the necessity of biopsy. The specialty society indicated that even a "negative" ultrasound in the setting of a palpable lump, or focal pain, or a finding on another imaging exam is quite intense. In these negative cases, the physician is under remarkable pressure to make absolutely sure no significant pathology is present. The RUC agreed that the intensity for these services has increased.

The specialty societies noted that the new breast ultrasound codes will be performed approximately 88% unilaterally and 12% bilaterally and that approximately 84% will perform the limited study and 16% will perform the complete study. A RUC member questioned whether imaging of the axilla is typically performed with the breast ultrasound. The specialty societies indicated that examining and imaging the axilla is typically performed together with the breast ultrasound, but is not reported separately. The specialty societies indicated that for staging the breast, the radiologist will typically examine the axilla. CMS confirmed that physicians are not currently reporting 76645 with 76882 *Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific.* The 2012 Medicare utilization data shows that CPT code 76645 was reported 862,941 times and CPT code 76882 was reported with 76645 only 3.4% or 5,808 times. Therefore, less than 1% of physicians were reporting these services together for the Medicare population.

7664X1 ***Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete***
The RUC reviewed the survey results from 51 radiologists for CPT code 7664X1 and determined that the survey 25th percentile work RVU of 0.73 appropriately accounts for the physician work required to perform this service. The RUC recommends 5 minutes of pre-service time, 12 minutes of intra-service time and 5 minutes of immediate post-

service time. The RUC noted that the radiologist interacts with the patient to a greater degree when conducting a breast ultrasound compared to other ultrasound codes. Additionally, the physician will typically talk to the patient directly for the immediate post-service period. The specialty societies estimated that the physician will include the axilla approximately 15-20% of the time for CPT code 7664X1. The RUC determined that the survey respondents may have indicated a median survey response including the work of examining the axilla and therefore recommend that the survey 25th percentile work RVU is more appropriate. The RUC compared the surveyed service to the key reference service 76816 *Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus* (work RVU = 0.85) and determined that 76816 requires more physician work and time and therefore should be valued higher. For additional support the RUC referenced MPC codes 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU = 0.75) and 76830 *Ultrasound, transvaginal* (work RVU = 0.69). **The RUC recommends a work RVU of 0.73 for CPT code 7664X1.**

7664X2 ***Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited***
The RUC reviewed the survey results from 51 radiologists for CPT code 7664X2 and determined that the survey 25th percentile work RVU of 0.68 appropriately accounts for the physician work required to perform this service. The RUC recommends 5 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of immediate post-service time. The RUC noted that the radiologist interacts with the patient to a greater degree when conducting a breast ultrasound compared to other ultrasound codes. Additionally, the physician will typically talk to the patient directly for the immediate post-service period. The specialty societies estimated that the physician will include the axilla approximately 25-30% of the time for CPT code 7664X2. The RUC determined that the survey respondents may have indicated a median survey response including the work of examining the axilla and therefore recommend that the survey 25th percentile work RVU is more appropriate. The RUC compared the surveyed service to the key reference service 77055 *Mammography; unilateral* (work RVU = 0.70) and determined that both services require similar physician work. For additional support, the RUC referenced MPC codes 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU = 0.75) and 76830 *Ultrasound, transvaginal* (work RVU = 0.69) **The RUC recommends a work RVU of 0.68 for CPT code 7664X2.**

The RUC noted that the October 2013 recommendations are outlined in the attached spreadsheet. The RUC confirmed that the breast ultrasound recommendations are appropriate relative to the previously recommended ultrasound codes.

Practice Expense
The RUC recommends the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

<u>Radiation Treatment Delivery (Tab 14)</u>
Najeeb Mohideen, MD, Micheal Kuettel, MD, PhD, David Beyer, MD, Dwight

Heron, MD, Gerald White, James Goodwin, William Noyes, MD and Paul Wallner, DO (ASTRO)

In October 2013, the CPT Editorial Panel deleted 14 codes (including two Category III codes); established three new codes to report intensity modulated radiation therapy: simple, complex and guidance for localization for delivery of radiation therapy; revised three codes to report radiation treatment delivery: simple, intermediate and complex. In addition, significant additions to guidelines were added, including a table of radiation management and treatment codes to clarify which codes contain the technical or professional work components.

77014 ***Computed tomography guidance for placement of radiation therapy fields***
CPT Code 77014 C*omputed tomography guidance for placement of radiation therapy fields* (work RVU= 0.85) is currently used to report CT with simulation and imaging guidance. The specialty societies explained that with coding changes in both the simulation codes in CPT 2014 and the treatment delivery/IGRT codes in CPT 2015, they expect utilization to drop to negligible levels by 2015. Currently 77014 is a high volume code and there may still be some situations where this code may be required. In October 2013 the CPT Editorial Panel decided not to delete the code along with the other IGRT codes, CPT code 77421 and 76950, based on concerns that without this option, some might have no valid CPT alternative other than use of higher valued diagnostic CT codes. **The specialties recommended and the RUC agreed that 77014 be re-reviewed once the new radiation treatment delivery codes go into effect and two years of Medicare data are available. The RUC recommends no change in the work RVU or practice expense direct inputs for CPT code 77014.**

Compelling Evidence
The specialties explained that the technique for delivering radiation therapy is significantly different and now includes some techniques previously reported as intensity modulated radiation therapy (IMRT). Image guided radiation therapy (IGRT) technology has evolved from using third party vendor hardware and software to the use of integrated technology. In the revised CPT code set IMRT and IGRT are bundled together. The specialty societies explained that new knowledge/technology has altered radiation delivery as well. The codes reflect the inclusion of tracking technology previously reported with category III codes. There have also been significant changes in the design of the linac machines used to delivery radiation treatment. The linac machines are now fully integrated digital treatment delivery equipment capable of delivering all energies in therapeutic use including electrons. The previous generations of single low energy linacs are no longer commercially available.

The specialty societies explained that advances in technology have changed the clinical staff time required for these codes. There are now mandated patient and staff safety requirements which were developed after catastrophic accidents during radiation treatment delivery. The change in technology has placed increased emphasis on patient safety, training and accreditation requirements and the American Society of Radiologic Technologists (ASRT) now require two qualified personnel at all times on each machine for patient setup and treatment. All parameters, electronic read outs, monitoring units and beam modifiers have to be confirmed in the room and cross-checked outside and inside the room by independent radiation therapists. While treatment is ongoing, one radiation therapist watches the console, monitor units and treatment parameters and the other watches the patient and machine movement in the room. **The PE Subcommittee**

considered the compelling evidence presented and determined that they would consider an increase in the time and equipment for the CPT codes.

77402 ***Radiation treatment Delivery; simple***
77407 ***Radiation treatment Delivery; intermediate***
77412 ***Radiation treatment Delivery; complex***
The specialty societies developed recommendations for practice expense (PE) only, as the standard radiation treatment delivery codes do not require physician work. The specialty societies used a modified PE survey tool, reviewed and approved by the Research Subcommittee to conduct a random survey of their office based membership. The PE Subcommittee reviewed the survey results from 99 radiation oncologists and noted that the survey and recommended times are higher than the current clinical staff times. Additionally the specialty is recommending different equipment than what is currently utilized for the treatment.

The RUC discussed that there may be potential overlap with the planning and management services that are billed with the treatment, however the staff responsible for the planning and management and the work performed by the RN/LPN/MTA (L037D) in the pre-service period and the RT (L050C) in the service and post-service period is specifically attributable to this code. The RUC also discussed that when the service was last reviewed in September 2002 some of the pre-service and post-service time in the service period was combined into the intra-service time. The RUC also discussed that many of the PE standards that currently exist did not exist at that time. The RUC agreed with the specialty that although the beam-on time has decreased because of efficiencies gained from new technology, the overall clinical labor time has increased substantially because of practice expense standards and potential errors in allocation of clinical staff time when the codes were previously reviewed.

The RUC discussed in detail the need for two radiation therapists (RT) to safely perform the service. The RUC strongly agrees with the specialty societies that there are clear guidelines requiring two RTs to meet the current standard of care, and agrees with the specialty that both RTs are doing concurrent, but distinct clinical activities critical in performing the service.

The RUC also discussed that the equipment has changed significantly since the codes were previously reviewed in September 2002. The linac machine is an accelerator capable of delivering all energy levels including electrons, so separate equipment for simple, intermediate and complex courses of treatment are no longer necessary and the *accelerator, 4-6 MV* (ER009) and *accelerator, 6-18 MV* (ER010) would not be used and are no longer commercially available. Previously the accelerator was the only piece of equipment needed, but the linac accelerator requires other pieces of equipment to function properly, such as the *laser diode* (ER040), *intercom* (EQ139), *power conditioner* (new) and the *record and verify system* (ER090). These equipment items are not only separate, but are purchased from different suppliers. The specialty has provided invoices for these direct practice expense equipment inputs. **The RUC reviewed and approved the direct practice expense inputs with minor modification as approved by the Practice Expense Subcommittee.**

774X1 Intensity modulated treatment delivery, includes guidance and tracking when performed: simple

The specialties developed recommendations for practice expense (PE) only, as CPT code 774X1 does not require physician work. The specialty societies used a modified PE survey tool, reviewed and approved by the Research Subcommittee to conduct a random survey of their office based membership. The PE Subcommittee reviewed the survey results from 99 radiation oncologists and noted that the specialty is recommending different equipment than what is currently utilized for the reference code, CPT code *77418 Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*.

The RUC discussed in detail the need for two radiation therapists (RT) to safely perform the service. The RUC strongly agrees with the specialty societies that there are clear guidelines requiring two RTs to meet the current standard of care, and agrees with the specialty that both RTs are doing concurrent, but distinct clinical activities critical in performing the service.

The RUC also discussed that new equipment *on board imaging* and *power conditioner* are now necessary for this treatment. The specialty has provided invoices for these direct practice expense equipment inputs. **The RUC reviewed and approved the direct practice expense inputs with minor modification as approved by the Practice Expense Subcommittee.**

774X2 Intensity modulated treatment delivery, includes guidance and tracking when performed: complex

The specialties developed recommendations for practice expense (PE) only, as CPT code 774X2 does not require physician work. The specialty societies used a modified PE survey tool, reviewed and approved by the Research Subcommittee to conduct a random survey of their office based membership. The PE Subcommittee reviewed the survey results from 99 radiation oncologists and noted that the survey and recommended times are higher than the current clinical staff times. Additionally the specialty is recommending different equipment than what is currently utilized for the reference code, CPT code *77418 Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*.

The RUC discussed in detail the need for two radiation therapists (RT) to safely perform the service. The RUC strongly agrees with the specialty societies that there are clear guidelines requiring two RTs to meet the current standard of care, and agrees with the specialty that both RTs are doing concurrent, but distinct clinical activities critical in performing the service.

The RUC also discussed that new equipment *on board imaging* and *power conditioner* are now necessary for this treatment. The specialty has provided invoices for these direct practice expense equipment inputs. **The RUC reviewed and approved the direct practice expense inputs with minor modification as approved by the Practice Expense Subcommittee.**

7742X3 ***Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking when performed***

CPT Code 7742X3 was created to replace the current IGRT codes, CPT codes 77421 and 76950. The RUC reviewed the surveys of 95 radiation oncologists and determined that a work RVU of 0.58 (3 minutes pre-service, 10 minutes intra-service and 3 minutes post-

service) lower than the survey 25th percentile, appropriately accounts for the physician work of this service. The RUC noted that this is a bundled code and the RUC considered the work RVUs of the deleted codes when determining the value of this service to maintain budget neutrality. The RUC also noted that treatment delivery codes 77402-77418, which do not include physician work, can be reported on the same date of service when image guidance is performed. The RUC compared the surveyed code to 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation*(work RVU=0.56) with identical intra-service time and determined that the surveyed code is slightly more intense to perform, accounting for the slightly higher work value. For further support, the RUC compared the surveyed code to MPC 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), the surveyed code is also more intense than this comparison code, accounting for the higher work value. **The RUC recommends a work RVU of 0.58 for CPT code 7742X3.**

Practice Expense
The specialty societies used a modified PE survey tool, reviewed and approved by the Research Subcommittee to conduct a random survey of their office based membership. The PE Subcommittee reviewed the survey results from 95 radiation oncologists and noted that the survey and recommended times are higher than the current clinical staff times. Additionally the specialty is recommending different equipment than what is currently utilized for reference codes 77014, 77421 and 76950.

The RUC discussed in detail the need for two radiation therapists (RT) to safely perform the service. The RUC strongly agrees with the specialty societies that there are clear guidelines requiring two RTs to meet the current standard of care, and agrees with the specialty that both RTs are doing concurrent, but distinct clinical activities critical in performing the service. The RUC also discussed that although this service will typically be billed with CPT code 77412, *radiation treatment delivery, complex*, the equipment is completely different and will require additional education and positioning of the patient.

The RUC also discussed that image guided radiation therapy (IGRT) technology has changed and that this service now needs to include an accelerator because the imaging guidance equipment is part of integrated digital treatment technology of the linac machine. Previously image guidance could be reported as a separate service. **The RUC reviewed and approved the direct practice expense inputs with minor modification as approved by the Practice Expense Subcommittee.**

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

<u>Bioimpedance Spectroscopy (Tab 15)</u>
Eric Whitacre, MD, FACS (ASBS)

In October 2013, the CPT Editorial Panel converted a Category III code to a Category I code to describe bioimpedance spectroscopy lymphedema assessment for extracellular fluid.

The RUC removed 3 minutes of time for follow-up phone calls and prescriptions from the pre-service period. The RUC also removed the equipment time for *computer, desktop, w-monitor* (ED021) and *printer, laser, paper* (ED032) because the equipment is not easily attributable to this service. **The RUC reviewed and approved the direct practice expense**

Brief Behavioral Assessment (Tab 16)
James Georgulakis, PhD (APA); Steven E. Krug, MD (AAP)

In October 2013, the CPT Editorial Panel created a new code to describe brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/ hyperactivity disorder (ADHD) scale), with scoring and documentation. In discussing the clinical labor time the Practice Expense Subcommittee requested clarification on the type of individual who was providing the scoring of a standardized pediatric inventory. The specialty societies decided to postpone the issue and seek clarification regarding whom performs the service, a non-physician qualified healthcare professional, clinical staff or administrative staff. At the February 2014 CPT Panel meeting the Panel removed language from the description of service that referred to a non-physician qualified healthcare professional as providing the service in order to clarify that it is clinical staff that provide and score the instrument. **The issue is postponed to the April 2014 RUC meeting.**

Negative Pressure Wound Therapy (Tab 17)
Charles Mabry MD (ACS); Mark Villa MD (ASPS); William Creevy, MD (AAOS); John Heiner, MD (AAOS); Seth Rubenstein, DPM (APMA); Timothy Tillo, DPM (APMA)

In the Final Rule for 2013, CMS created two HCPCS codes to provide a payment mechanism for negative pressure wound therapy services furnished to beneficiaries through means unrelated to the durable medical equipment benefit: G0456 *Negative pressure wound therapy,(eg vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters* and G0457 *Negative pressure wound therapy,(eg vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 sq cm*. The two new codes were contractor priced on an interim basis for CY 2013. CMS requested comments on the appropriate value for this service.

In January 2013, the RUC noted that industry individuals developed a Coding Change Proposal (CCP) to describe the NPWT disposable device, however subsequently withdrew the proposal. The RUC recommended that codes G0456 and G0457 be placed on the LOI to allow specialties that may have an interest a chance to survey and develop new PE inputs. No specialty societies indicated an interested in developing recommendations for these G-code services.

In April 2013, industry individuals again submitted a CCP to create two Category I codes to describe these services with the use of a disposable device. At the May 2013 CPT Editorial Panel meeting, two codes were established to report negative pressure wound therapy using a disposable device. CPT codes 97605 and 97606 were revised to specify durable medical equipment. Additionally, at the October 2013 meeting, the Relativity Assessment Workgroup identified CPT codes 97605 and 97606 through the High Volume Growth Screen, where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that these services be surveyed for physician work and develop practice expense inputs.

97605 Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

The RUC reviewed the surveyed pre-service time and agreed with the specialty society recommendation to decrease the pre-service time to 3 minutes and the immediate post-service time to 5 minutes. Although an Evaluation and Management (E/M) service is not typically performed with CPT code 97605 on the same day, the specialty societies indicated that another procedure or service would typically be performed prior to the application of a vacuum assisted drainage collection device. The RUC recommends 3 minutes pre-service, 20 minutes intra-service and 5 minutes immediate post-service time for CPT code 97605. The specialty society noted and the RUC agreed that the previous survey time data was incorrect as it was based on significantly less than 30 responses from a specialty that rarely reports the service.

The specialty societies indicated and the RUC agreed that the physician work required to perform this service has not changed and recommend maintaining the current work RVU of 0.55 for CPT code 97605. The specialty societies indicated and the RUC agreed that the 45 survey respondents overestimated the work required to perform this service. The survey respondents indicated a survey 25th percentile work RVU of 0.84 and a median work RVU of 1.00, well above the current work RVU of 0.55 for CPT code 97605. The specialty societies indicated that they reviewed the previous survey data from the 2004 HCPAC review of a survey conducted by physical therapists and agreed the time data was not valid, as it was based on only 17 responses from one specialty that represented less than 0.5% of the Medicare utilization. However, the specialty societies agreed with the HCPAC rationale to recommend 0.55 work RVUs for this code using a magnitude estimation comparison to code 97002 *Physical therapy re-evaluation* (work RVU= 0.60) andcode 97601 *Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session* (deleted in 2005).

The RUC compared 97605 to reference service 97597 *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; first 20 sq cm or less* (work RVU=0.51) and determined that 97605 requires slightly more physician work and time to perform. To further support the current work RVU of 0.55, the RUC used magnitude estimation and similar codes 29580 *Strapping; Unna boot* (work RVU = 0.55), 88104 *Cytopathology, fluids, washings or brushings, except cervical*

or vaginal; smears with interpretation (work RVU = 0.55) and 92570 *Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing* (work RVU = 0.55). **The RUC recommends a work RVU of 0.55 for CPT code 97605.**

97606 Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

The RUC reviewed surveyed pre-service time and agreed with the specialty society recommendation to decrease the pre-service time to 3 minutes and the immediate post-service time to 5 minutes. Although an Evaluation and Management (E/M) service is not typically performed with CPT code 97606 on the same day, the specialty societies indicated that another procedure or service would typically be performed prior to the application of a vacuum assisted drainage collection device. The RUC recommends 3 minutes pre-service, 30 minutes intra-service and 5 minutes immediate post-service time for CPT code 97606. The specialty society noted and the RUC agreed that the previous survey time data was incorrect as it was based on significantly less than 30 responses from a specialty that rarely reports the service.

The specialty societies indicated and the RUC agreed that the physician work required to perform this service has not changed and recommend maintaining the current work RVU of 0.60 for CPT code 97606. The specialty societies indicated and the RUC agreed that the 30 survey respondents overestimated the work required to perform this service. The survey respondents indicated a survey 25th percentile work RVU of 1.21 and a median work RVU of 1.73, well above the current work RVU of 0.60 for CPT code 97606. The specialty societies indicated that they reviewed the previous survey data from the 2004 HCPAC review of a survey conducted by physical therapists and agreed the time data was not valid, as it was based on only 16 responses from one specialty that represents less than 0.2% of the Medicare utilization. However, the specialty societies agreed with the HCPAC rationale to recommend 0.60 work RVUs for this code using magnitude estimation that 97606 is more work than the base code 97605 and code 97601 *Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session* (deleted in 2005).

To further support the current work RVU of 0.60, the RUC used magnitude estimation and similar codes 11300 *Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less* (work RVU = 0.60), 92557 *Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)* (work RVU = 0.60) and 95940 *Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.60). **The RUC recommends a work RVU of 0.60 for CPT code 97606.**

976XX11 Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment (DME) including provision of exudate management collection system, topical application(s), wound

assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters

The RUC reviewed surveyed pre-service time for CPT code 976XX11 and agreed with the specialty society recommendation to decrease the pre-service time to 3 minutes and the immediate post-service time to 5 minutes to be consistent with this family of services. Although an Evaluation and Management (E/M) service is not typically performed with CPT code 976XX11 on the same day, the specialty societies indicated that another procedure or service would typically be performed prior to the application of a vacuum assisted drainage collection device. The specialty societies indicated and the RUC agreed that the survey median intra-service time of 15 minutes accurately accounts for the work which involves prepping the surrounding skin, hand cutting the sponge and applying the flat plastic adhesive dressing to a contoured surface. The RUC recommends 3 minutes pre-service, 15 minutes intra-service and 5 minutes immediate post-service time for CPT code 976XX11.

The specialty societies indicated that the median service performance rate was zero and therefore did not use the survey's estimated physician work RVUs to value this service. However, in comparing the relationship of the durable medical equipment (DME) service 97605 to the non-DME service 976XX11, the RUC noted that the survey median work RVU for 976XX11 was lower than that of 97605. Additionally, the typical wound for 976XX11 is more stable, more mature than the type of wound treated by the durable medical equipment service 97605, thus requiring slightly less physician work. The specialty societies indicated that a lower work RVU for 976XX11 compared to 97605 is supported by current Medicare coverage policy for reporting the new device, that states "…disposable NPWT is provided as an alternative to DME based NPWT in patients with wounds of short duration and no more than 2 applications of a disposable device would be expected. Otherwise the patient is a candidate for DME based NPWT."[i]

The primary difference in the DME and non-DME codes is the physician time required to perform the service. Therefore, the specialty societies used magnitude estimation and the ratio of intra-service time of 97605 to 976XX11, which was 15:20 or 75% (97605 work RVU 0.55 x 0.75 = 0.41). The RUC compared 976XX11 to similar services 29540 *Strapping; ankle and/or foot* (work RVU = 0.39), 94453 *High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration* (work RVU = 0.40), 92286 *Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis* (work RVU = 0.40) and 88108 *Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)* (work RVU = 0.44). The RUC determined that a work RVU of 0.41 places this service in the proper rank order relative to 97605 and other similar services. **The RUC recommends a work RVU of 0.41 for CPT cod 976XX11.**

976XX12 Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment (DME) including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters

The RUC reviewed surveyed pre-service time for CPT code 976XX12 and agreed with the specialty society recommendation to decrease the pre-service time to 3 minutes and

the immediate post-service time to 5 minutes to be consistent with this family of services. Although an Evaluation and Management (E/M) service is not typically performed with CPT code 976XX12 on the same day, the specialty societies indicated that another procedure or service would typically be performed prior to the application of a vacuum assisted drainage collection device. The specialty societies indicated and the RUC agreed that the intra-service time of 23 minutes (using the ration between the DME and non-DME physician time codes 97606 (30 minutes x 77% = 23) accurately accounts for the work which involves prepping the surrounding skin, hand cutting the sponge and applying the flat plastic adhesive dressing to a contoured surface. The RUC recommends 3 minutes pre-service, 23 minutes intra-service and 5 minutes immediate post-service time for CPT code 976XX12.

The specialty societies indicated that the median service performance rate was zero and therefore did not use the survey's estimated physician work RUVs to value for this service. However, in comparing the relationship of the durable medical equipment (DME) service 97606 to the non-DME service 976XX12, the RUC noted that the survey median work RVU for 976XX12 was lower than that of 97606. Additionally, the typical wound for 976XX12 is more stable, more mature than the type of wound treated by the durable medical equipment service 97606, thus requiring slightly less physician work. The specialty societies indicated that a lower work RVU for 976XX12 compared to 97606 is supported by current Medicare coverage policy for reporting the new device, that states "…disposable NPWT is provided as an alternative to DME based NPWT in patients with wounds of short duration and no more than 2 applications of a disposable device would be expected. Otherwise the patient is a candidate for DME based NPWT." [ii]

The primary difference in the DME and non-DME codes is the physician time required to perform the service. Therefore, the specialty societies used magnitude estimation and the ratio of intra-service time of 97606 to 976XX12 was 23:30 or 77% (97606 work RVU 0.60 x 0.77 = 0.46). The RUC compared 976XX12 to similar services 88108 *Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)* (work RVU = 0.44), 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) and 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.48). The RUC determined that a work RVU of 0.46 places this service in the proper rank order relative to 97606 and other similar services. **The RUC recommends a work RVU of 0.46 for CPT cod 976XX12.**

New Technology
The RUC recommends that CPT codes 976XX11 and 976XX12 be placed on the new technology list for future review.

Flag in RUC Database
The RUC recommends to flag CPT codes 976XX11 and 976XX12 as "do not use for validation of work" since the value was derived from a calculation of time related to the DME associated codes 97605 and 97606.

Practice Expense
The RUC noted that for CPT codes 976XX11 and 976XX12 the assumption is that these are single use disposable devices. When a patient comes in for evaluation of the wound, it can not be evaluated if the device is left on, therefore it is taken off. The RUC

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

Selective Head and Total Body Hypothermia (Tab 18)
Steve Krug, MD, FAAP and Stephen Pearlman, MD, FAAP (AAP)

In October 2013, the CPT Editorial Panel deleted two codes and established one Category I code to report both selective head and total body hypothermia in the critically ill neonate.

The RUC reviewed the survey results from 100 pediatricians and determined that the survey median work RVU of 4.50 appropriately accounts for the work required to perform this service. The RUC agreed with the specialty societies that the physician time required to perform this service is 30 minutes pre-service time, 60 minutes intra-service time and 20 minutes immediate post-service time. The RUC questioned if this service would be typically reported with 99465 *Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output*. The specialty societies confirmed that all neonates receiving this service would require resuscitation, therefore XXXXX would be reported with 99465. The specialty societies indicated that the pre-service work includes evaluating the patient for eligibility to receive this service, conducting a detailed discussion with the family as well as the conducting and interpreting the amplitude integrated EEG. An amplitude integrated EEG requires 20 minutes to perform and needs to be checked regularly to see if it meets specific criteria. The amplitude EEG is included in this service and not reported separately as specified in the CPT descriptor. Therefore, the RUC agreed that 30 minutes for pre-service time is appropriate. The specialty society indicated that the post-service time includes documentation of outcomes and response to the therapy and additional discussion with the family. CPT code XXXXX describes the initiation for cooling but the procedure itself continues for three days. The specialty society indicated and the RUC agreed that the survey respondents may have overestimated the immediate post-service time of this imitation service and recommended decreasing the immediate post-service time from 40 minutes to 20 minutes. The specialty societies confirmed that this service may only be reporting once since it is for the initiation.

The RUC compared the surveyed code to the key reference service 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU = 4.50) and agreed that the typical patient for both services are critically ill/critically injured and require similar intensity and complexity to treat. For further support, the RUC referenced similar service 31661 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes* (work RVU = 4.50). **The RUC recommends a work RVU of 4.50 for CPT code XXXXX.**

Practice Expense
No practice expense recommendations for this facility-only service.

End of Life Care-Advance Directive Plan (Tab 19)
John Agens, MD (AGS), Mary Newman, MD (ACP), Alan Plummer, MD (ACCP/ATS), Phil Rodgers, MD (AGS), Marianna Spanaki, MD (AAN), Tom Weida, MD (AAFP)

Facilitation Committee #2

In October 2013, the CPT Editorial Panel created two new codes to describe the face-to-face encounter and time that a patient's treating physician spends with the patient, his/her family, or healthcare power of attorney discussing advance directive planning. Factors considered in this discussion include the patient's current disease state, disease progression, available treatments, cardiopulmonary resuscitation/life sustaining measures, do not resuscitate orders, life expectancy considering the patient's age and co-morbidities, and clinical recommendations of the treating physician; including reviews of patient's past medical history and medical documentation/reports as well as response(s) to previous treatments.

The RUC noted concern for potential over reporting of this service when only general advance directive services are conducted. The specialty societies noted and the Committee agreed that regular advanced directives may already currently be reported as part of an Evaluation and Management (E/M) service; however CPT codes 9949X7 and 9949X8 include separate advanced directive planning, palliative care and detailed advance care planning determinations.

9949X7 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate
The RUC reviewed the survey results from 273 physicians and determined that the survey median of 1.50 work RVUs and 5 minutes of pre-service time, 30 minutes of intra-service time and 10 minutes of immediate post-service time accurately account for the physician work required to perform this service. The Committee noted that the specialty society decreased the pre-service time from 10 to 5 minutes to account for any duplication when performed with an E/M. The Committee compared 9949X7 to key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient,* (work RVU = 1.50) and agreed that the physician work required to perform these services is the same. The Committee also compared 9949X7 to 90832 *Psychotherapy, 30 minutes with patient and/or family member* (work RVU = 1.50) which requires the same physician work and the same physician time of 5 minutes pre-service, 30 minutes intra-service and 10 minutes immediate post-service time. **The RUC recommends a work RVU of 1.50 for CPT code 9949X7.**

9949X8 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; each additional 30 minutes (List separately in addition to code for primary procedure)
The specialty societies indicated that the typical 9949X8 add-on service is a continuation of more than 45 minutes of discussion typically involving consensus of the patient and or multiple children/family members of the patient.

The RUC reviewed the survey results from 273 physicians and determined that the survey median of 1.40 work RVUs and 30 minutes intra-service time accurately accounts for the physician work required to perform this service. The Committee compared 9949X8 to key reference service 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), noting 99292 requires more physician work. The Committee also compared 9949X8 to CPT code 90832 *Psychotherapy, 30 minutes with patient and/or family member* (work RVU = 1.50, if multiplied by 2 totals 60 minutes and 3.00 work RVUs) and determined that an 60 minutes of advance care planning, 9949X7 + 9949X8 = 2.90, is more intense than 60 minutes of 90832 because the last 30 minutes of psychotherapy is less intense than the physician work associated 9949X8. The Committee determined that a work RVU of 1.40 for CPT code 9949X8 appropriately places this service in the proper rank order relative to other similar services. **The RUC recommends a work RVU of 1.40 for CPT code 9949X8.**

Future Review
The RUC recommends review of 9949X7 and 9949X8 in 3 years (September 2017).

Referred to CPT Assistant
The RUC recommends that codes 9949X7 and 9949X8 be referred to CPT Assistant to educate physicians on how to code this service correctly.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

XI. CMS Request/Relativity Assessment Identified Codes

<u>Hormone Pellet Implantation (Tab 20)</u>
Thomas Turk, MD and Philip Wise, MD, (AUA)
Facilitation Committee #3

At the October 2013, meeting the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that these services be surveyed for physician work and develop practice expense inputs for the January 2014 RUC meeting. In January 2014 the RUC questioned whether CPT code 11981 should also be reviewed since it is "CMS/Other" and has not been reviewed. **The RUC requests the specialty societies submit an action plan to the RAW in April to consider whether 11981 is part of this family and should be surveyed.**

The RUC discussed the physician time and intensity associated with CPT Code 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* and the appropriate work RVU relative to similar services. The specialty societies indicated and the RUC agreed that 10 minutes of pre-service time, 12 minutes of intra-service time, and 5 minutes of post-service time, adequately accounts for the physician time required to perform this service. The RUC noted that the time has decreased since this code was last reviewed in February 2000 and acknowledged that the reduction in time may be a result of the creation of pre- and post-time packages. Based on this reduction in time, rather than maintain the current work RVU, the RUC recommended a direct crosswalk to CPT Code 11730 *Avulsion of nail plate, partial or complete, simple; single* (work RVU=1.10) with identical intra service time of 12 minutes and similar intensity. To further support the value the RUC compared the surveyed code to CPT Code 51705 *Change of cystostomy tube; simple* (work RVU= 0.90) and agreed that 11980 should be valued higher since this requires more physician work. The RUC also compared CPT Code 11980 to CPT Code 67810 *Incisional biopsy of eyelid skin*

including lid margin (work RVU=1.18) and agreed that this procedure requires slightly more physician time and intensity, accounting for the higher work value. **The RUC recommends a work RVU of 1.10, a direct crosswalk to CPT code 11730 for CPT code 11980.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

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

Injection for Knee Arthrography (Tab 21)
Ezequiel Silva, III, MD (ACR); William Creevy, MD (AAOS)

At the October 2013 meeting, the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that these services be surveyed for physician work and develop practice expense inputs. At the February 2014 CPT Editorial Panel meeting, the specialty societies submitted a Code Change Proposal (CCP) to address the high growth of this code. The Panel approved editorial revisions replacing the term "procedure" for "of contrast." This revision to the descriptor clarifies that the correct use of 27370 is to describe the injection of contrast into the knee joint space for arthrography only. The specialty societies noted that the high volume growth for this procedure is likely due to its being reported incorrectly as arthrocentesis or aspiration. The correct reporting of those services is CPT code 20610 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance* (work RVU= 0.79).

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.

Endobronchial Ultrasound (Tab 22)
Katina Nicolacakis MD (ATS), Alan Plummer, MD (ATS), Robert DeMarco, MD (ACCP), Burt Lesnick (ACCP) and Kevin Kovitz, MD (ACCP)

In October 2013, the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that these services be surveyed for physician work and develop practice expense inputs.

The specialty societies indicated and the RUC agreed that there has been a change in instrumentation and typical patient due to new technology. The equipment for Endobronchial Ultrasound (EBUS) has evolved since CPT code 31620 was last surveyed and evaluated by the RUC in 2004. The physician work has changed in the following ways:

1) Currently there is a separate bronchoscope that has the EBUS probe built into the tip. This is the standard technique for obtaining EBUS guided biopsies from mediastinal and hilar locations.
2) The technique for using the newer bronchoscope requires the acquisition of new skills as the camera is at a 30 degree angle from the tip of the scope. The operator has to navigate the bronchoscope looking at the airway from an angle rather than the end of the scope.
3) The ultrasound is visualized in real time during the biopsy procedure, and needs to be continuously adjusted in the field of view. This is a change from the prior technique in which the target was visualized and then the ultrasound (US) catheter removed to allow for the biopsy needle/forceps to be inserted into the same channel.

The RUC reviewed the survey responses from 256 physicians and determined that the survey 25th percentile work RVU of 1.50 and survey 25th percentile physician intra-service time of 40 minutes appropriately accounts for the physician work and time required to perform this service. The RUC questioned whether this add-on code could be used as an add-on to a variety of different codes that already include the work of performing a biopsy. The specialty societies clarified that the work of base code 31629 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (work RVU = 4.09 and 30 minutes intra-service time) includes the insertion of the standard bronchoscope, surveying the airways, and removal of the bronchoscope. Following this, CPT code 31620 is reported when the EBUS scope is inserted and the physician surveys all the lymph nodes. The intra-service work of CPT code 31620 ends when the biopsies begin. EBUS is merely the vehicle to get to the biopsies and does not include the work of performing the biopsies. The biopsy work is included in the base code 31629. For example, the intra-service work for 31629 is 30 minutes, 25 minutes of that time is to insert the bronchoscope and 5 minutes to perform the biopsy, in the middle of those two functions are 40 minutes to insert the EBUS and preparing to perform the biopsy.

The RUC questioned whether or not the survey respondents excluded the physician work and time to perform the biopsy when they estimated their times. To ensure that the valuation of this service does not include duplicative physician work with conducting the biopsy, the RUC determined that the survey 25th percentile intra-service time of 40 minutes is more appropriate. The RUC compared 31620 to key reference service *31633 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe* (work RVU = 1.32 and 20 minutes of intra-service time) and determined that the key reference service is less intense and complex and requires half the physician time to perform and therefore is valued lower. For additional support, the RUC referenced similar add-on code 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 1.44 and 30 minutes intra-service) which requires slightly less physician work and time to perform. **The RUC recommends a work RVU of 1.50 for CPT code 31620**.

Refer to CPT
The RUC recommends referring CPT code 31620 to the CPT Editorial Panel to clarify that there is no overlap regarding the work of performing the biopsy(ies) associated with base code 31629 and other base codes in which add-on CPT code 31620 would be typically be reported.

Flag in RUC Database
Due to the use of the 25th percentile physician time, the RUC recommends flagging CPT code 31620 in the RUC database as not to use to validate for physician work or time.

Practice Expense
The RUC recommends the direct practice expense inputs as presented and accepted by the Practice Expense Subcommittee.

Bronchoscopy-Computer Assisted (Tab 23)
Burton L. Lesnick, MD (ACCP); Alan L. Plummer, MD (ATS)

CPT code 31627 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation* was identified through the New Technology/New Services List in February 2009. In October 2013, the Relativity Assessment Workgroup noted there may have been diffusion in technology for this service and requested that the practice expense direct inputs be reviewed at the January 2014 meeting and that the RAW review the data again in 3 years (September 2016). **The RUC reviewed and approved the direct practice expense inputs without modification as approved by the Practice Expense Subcommittee.**

Laparoscopic Hysterectomy (Tab 24)
George A. Hill, MD (ACOG)
These services were identified through the New Technology/New Services List in April 2007. In October 2013, the Relativity Assessment Workgroup noted there may have been diffusion in technology for this service and requests that the specialty society's survey physician work and review practice expense at the January 2014 meeting.

The specialty societies requested and the RUC agreed that these services be postponed to April 2014 RUC meeting. The specialty societies determined that the vignettes to be included in the survey were not typical. The vignettes will be revised to reflect typical patients for these procedures. **The RUC recommends that these services be postponed and surveyed for physician work and develop direct practice expense inputs for the April 2014 RUC meeting.**

Percutaneous Implantation of Neuroelectrodes (Tab 25)
Norm Smith, MD (AUA); Philip Wise, MD (AUA); George Hill, MD (ACOG)
Facilitation Committee #2

At the October 2013, meeting the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that these services be surveyed for physician work and develop practice expense inputs for the January 2014 RUC meeting.

64561 Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed
The RUC reviewed the survey results from 83 urologists and gynecologists and determined that the survey 25th percentile work RVU of 6.88 was too high because the physician intra-service time required to perform this service had decreased 20 minutes from when it was last evaluated in 2001. Although the current work RVU for CPT code

64561 is 7.15, the Committee determined that the efficiencies gained account for a higher decrease in work RVUs. The Committee compared 64561 to MPC code 52235 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)* (work RVU = 5.44 and 29 minutes pre-service, 45 minutes intra-service time and 20 minutes immediate post-service time) and recommends a direct crosswalk. This brings the intensity required to perform this service in line with other similar services. For additional support, the Committee referenced 33213 *Insertion of pacemaker pulse generator only; with existing dual leads* (090 global, work RVU = 5.53 and 46 minutes intra-service time and 1-99213). The RUC determined that 22 minutes pre-evaluation, 5 minutes positioning, 45 minutes intra-service time and 19 minutes immediate post service time and one 99214 office visit for CPT code 64561 appropriately account for the work required to perform this service. **The RUC recommends a work RVU of 5.44 for CPT code 64561.**

X-Ray Exams (Tab 26)
Ezequiel Silva, III, MD (ACR); William Creevy, MD (AAOS); Joshua Hirsch, MD (ASNR)

The Relativity Assessment Workgroup identified these services through the CMS/Other Source – Utilization over 250,000 screen. In October 2013, the RUC noted that these services were never RUC reviewed but are frequently reported. The RUC recommended that these services be surveyed for physician work and develop direct practice expense inputs for the January 2014 RUC meeting. The specialty society presented a crosswalk methodology to validate the existing values for these plain film codes. The RUC did not accept the crosswalk methodology and requested action of the specialty societies by the September 2014 RUC meeting, acknowledging that the specialty societies may again pursue an alternative methodology through the Research Subcommittee. The Research Subcommittee considered the request during their March 4, 2014 meeting and determined that these services should be surveyed because they have not been recently reviewed. **The RUC recommends that these services be surveyed for physician work and develop direct practice expense inputs for the September 2014 RUC meeting.**

CT Angiography-Chest (Tab 27)
Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Gerald Niedzwiecki, MD (SIR), Michael Hall, MD (SIR)
Facilitation Committee #3

In October 2008, CPT code 71275 *Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing* was identified through the CMS Fastest Growing screen and later the MPC List screen. The RUC reviewed Medicare utilization in September 2011 and at the October 2013 meeting determined that this service should be surveyed for physician work and practice expense for review at the January 2014 RUC meeting.

The RUC reviewed the survey results from 89 physicians for CPT code 71275. The societies indicated, and the RUC agreed, that 5 minutes of pre-service time, 25 minutes of intra-service time and 5 minutes of post-service time, adequately account for the physician time required to perform this service. Based on these surveyed times, the RUC determined that a work RVU of 1.90, the survey 25th percentile, was not appropriate for this service. The RUC noted that the physician time significantly decreased from the survey that was presented to the RUC in February 2001. In order to maintain relatively

across the family of computed tomography codes the RUC compared 71275 to recently reviewed CPT code 74177 *Computed tomography, abdomen and pelvis; with contrast material(s)* (work RVU=1.82). The RUC determined that a direct crosswalk to 74177, with identical pre, intra, and post time, accounts for the physician work and time associated with the surveyed code.

To further support this value, the RUC reviewed CPT code 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU= 1.82) and determined that physician work and intensity are similar. Additionally the RUC noted that CPT code 74175 *Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing* with identical pre, intra and post time was reviewed at the October 2013 RUC meeting and the RUC approved a value of 1.82. **The RUC recommends a work RVU of 1.82 for CPT code 71275.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee.

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

<u>Swallowing Function (Tab 28)</u>
Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Joshua Hirsch, MD (ASNR); Greg Nicola, MD (ASNR)
The RUC identified CPT code 74230 through the CMS/Other Source – Utilization over 250,000 screen. In October 2013, the RUC noted that this service was never RUC reviewed but is frequently reported. The RUC recommended that these services be surveyed for physician work and develop direct practice expense inputs for the January 2014 RUC meeting.

The RUC reviewed the survey results from 60 radiologists and neuroradiologtists for CPT code 74230 *Swallowing function, with cineradiography/videoradiography* and determined that the current work RVU of 0.53 should be maintained. The RUC recommends 3 minutes pre-service time, 10 minutes intra-service time and 4 minutes immediate post-service time. A RUC member questioned how often the radiologist reviews the video recording, in which the specialty societies indicated that the radiologists typically reviews a portion of the video in specific instances to review when there laryngeal penetration, aspiration or pooling of ingested material occurred. However, the radiologist does not typically review the entire video recording. The RUC compared 74230 to the key reference service 74247 *Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, with KUB* (work RVU = 0.69) and determined that the surveyed service requires less physician work and 5 minutes less intra-service time to complete and therefore appropriately valued the surveyed code lower. For additional support, the RUC referenced MPC code 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU = 0.56), which requires similar physician work and both

require 10 minutes of intra-service time and therefore should be valued similarly. **The RUC recommends a work RVU of 0.53 for CPT code 74230.**

Practice Expense
The RUC recommends the direct practice inputs as reviewed by the Practice Expense Subcommittee with no modifications.

Microdissection (Tab 29)
Jonathan L. Myles, MD (CAP); Lee H. Hilborne, MD (ASCP); Mahesh Mansukhani, MD (ASCP)

CPT code 88381 was identified through the New Technology/New Services List in February 2007. In October 2013, the Relativity Assessment Workgroup noted there may have been diffusion in technology for this service and requests that the specialty society's survey physician work and review practice expense at the January 2014 meeting. Code 88380 was added as part of this family.

88380 ***Microdissection (ie, sample preparation of microscopically identified target); laser capture***
The RUC reviewed the survey results from 31 pathologists and agreed with the specialty societies that 33 minutes of intra-service time, with 0 pre and post time is appropriate for this service. The RUC noted that while the survey median intra-service time indicated 28 minutes, there was 5 additional minutes in the pre-service component that is more accurately captured in the intra-service component. The specialty societies explained that pathologists must perform additional work prior to actually performing the microdissection. These include evaluating where the sample is located appropriate for the assay and ensuring this procedure will answer the appropriate clinical question being asked by the referring physician. For pathology services the RUC specifies intra-service time as anything the physician does from the time the laboratory receives the specimen until it is signed out. Therefore, the RUC agreed that it was appropriate to move the 5 minutes associated with this work to the intra-service time.

To value this procedure, the RUC noted that due to the decrease in intra-service time from the current time, 45 minutes, to the survey time, 33 minutes, a decrease in the current work RVU of 1.56 was appropriate. Therefore, the RUC agreed that the survey 25th percentile work RVU of 1.14 was appropriate for CPT code 88380. To justify this value, the RUC compared the surveyed code to CPT codes 88120 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* (work RVU= 1.20, intra time= 30 minutes) and 88360 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual* (work RVU= 1.10, intra time= 35 minutes) and agreed that these two pathology codes, with similar intra-service times and physician work, are appropriate validations for the recommended value for 88380. In addition, the RUC reviewed a service outside the pathology family and noted that CPT code 77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)* (work RVU= 1.24, intra time= 35) has slightly greater intra-service time compared to the surveyed code and is appropriately valued slightly higher. **The RUC recommends a work RVU of 1.14 for CPT code 88380.**

88381 ***Microdissection (ie, sample preparation of microscopically identified target); manual***
The RUC reviewed the survey results from 64 pathologists and agreed with the specialty societies that 20 minutes of intra-service time, with 0 pre and post time is appropriate for this service. The RUC noted that while the survey median intra-service time indicated 15 minutes, there was 5 additional minutes in the pre-service component that is more accurately captured in the intra-service component. The specialty societies explained that pathologists must perform additional work prior to actually performing the microdissection. These include evaluating where the sample is located appropriate for the assay and ensuring this procedure will answer the appropriate clinical question being asked by the referring physician. For pathology services the RUC specifies intra-service time as anything the physician does from the time the laboratory receives the specimen until it is signed out. Therefore, the RUC agreed that it was appropriate to move the 5 minutes associated with this work to the intra-service time.

To value this procedure, the RUC noted that due to the decrease in intra-service time from the current time, 30 minutes, to the survey time, 20 minutes, a decrease in the current work RVU of 1.18 was appropriate. Therefore, the RUC agreed that the survey 25th percentile work RVU of 0.53 was appropriate for CPT code 88381. To justify this value, the RUC compared the surveyed code to CPT codes 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (work RVU= 0.69, intra time= 20 minutes) and 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (work RVU= 0.62, intra time= 20 minutes) and agreed that these two pathology codes, with identical intra-service time and physician work, are appropriate validations for the recommended value for 88381. **The RUC recommends a work RVU of 0.53 for CPT code 88381.**

Practice Expense:
The direct practice expense inputs were reviewed by the Practice Expense Subcommittee and several changes were made to the existing PE inputs. First, while the total times are not changing, much of the clinical labor work is moving from histotechnologists (L037B) to cytotechnologists (L045A). In addition, the number of microscope slides has risen from 2 to 11 and 9, respectively. This reflects the shift of molecular pathology using gene sequencing and requiring more slides. Finally, several pieces of equipment were added including a fume hood to reflect current clinical practice. The RUC accepted the direct practice expense inputs as modified 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.

Doppler Echocardiography (Tab 30)
Richard Wright, MD (ACC); Michael Main, MD (ASE)

The Relativity Assessment Workgroup identified these services through the CMS/Other Source – Utilization over 250,000 screen. In October 2013, the RUC noted that these services were never RUC reviewed but are frequently reported. The RUC recommended that these services be surveyed for physician work and develop direct practice expense inputs for the January 2014 RUC meeting.

93320 ***Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete***
The RUC reviewed the survey results from 60 physicians and recommends maintaining the work RVU of 0.38 for CPT code 93320 as the physician work has not changed. The specialty societies indicated and the RUC agreed that 15 minutes of intra-service time, adequately accounts for the physician time required to perform this service. There is no pre- or post-service time associated with this code because it is an add-on code which describes the additional work of complete pulsed wave and/or continuous wave Doppler.

The RUC compared the surveyed code to key reference service 93308 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study* (work RVU=0.53, 15 minutes intra-service), with identical intra-service time and similar intensity. Although 93308 is an XXX code, respondents are more familiar with the commonly performed complete transthoracic echocardiography that includes pulsed wave and/or continuous wave Doppler. The higher RVU for 93308 is accounted for by the 5 minutes of pre- and post-service time. To support the recommended value the RUC also compared the surveyed code to ZZZ global services that require 15 minutes of physician intra-service time, CPT code 95885 *Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)* (work RVU=0.35), and CPT code 88177 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)* (work RVU=0.42). **The RUC recommends a work RVU of 0.38 for CPT code 93320.**

93321 ***Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)***
The RUC reviewed the survey results from 50 physicians and recommends maintaining the work RVU of 0.15 for CPT code 93321 as the physician work has not changed. The specialty societies indicated and the RUC agreed that 10 minutes of intra-service time, adequately accounts for the physician time required to perform this service. There is no pre- or post-service time associated with this code because it is an add-on code which describes the additional work of limited pulsed wave and/or continuous wave Doppler.

To support the recommended value the RUC also compared the surveyed code to ZZZ, MPC 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). The comparison code 96367 is more intense and complex than 93321, accounting for the higher work value. **The RUC recommends a work RVU of 0.15 for CPT code 93321.**

93325 ***Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)***
The RUC reviewed the survey results from 50 physicians and recommends maintaining the work RVU of 0.07 for CPT code 93325 as the physician work has not changed. The specialty societies indicated and the RUC agrees that 10 minutes of intra-service time, adequately accounts for the physician time required to perform this service. There is no

pre- or post-service time associated with this code because it is an add-on code which describes the work of Doppler color flow velocity mapping.

To support the recommended value the RUC also compared the surveyed code to ZZZ, MPC code 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)* (work RVU=0.10). The comparison code 96367 is more intense and complex than 93325, accounting for the higher work value. **The RUC recommends a work RVU of 0.07 for CPT code 93325.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee.

Continuous Glucose Monitoring (Tab 31)
Allan R. Glass, M.D. (TES); Mary Newman, M.D. (ACP); Howard Lando, M.D., FACP, FACE (AACE)

At the October 2013, meeting the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that these services be surveyed for physician work and develop practice expense inputs for the January 2014 RUC meeting.

At the January 2014 RUC meeting the specialty societies requested and the RUC agreed to refer CPT codes 9520 and 95251 to the CPT Editorial Panel to revise these services. The specialty societies indicated that will request revisions to differentiate between "professional CGM" in which a patient wears the CGM device for 72 hours and "personal CGM" where the patient owns the CGM device and wears it for an extended period of time. **The RUC recommends that CPT codes 95250 and 95251 be referred to the CPT Editorial Panel for revision.**

Electronic Analysis of Implanted Neurostimulator (Tab 32)
Thomas Turk, MD (AUA); Philip Wise, MD (AUA); Marc Lieb, MD (ASA); Karin Swartz, MD; (NASS); Christopher Merifield, MD (ISIS); George Hill, MD (ACOG); David Krencik, MD (AAPM)

At the October 2013, meeting the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that these services be surveyed for physician work and develop practice expense inputs for the January 2014 RUC meeting.

95971 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
The RUC reviewed the survey results from 66 physicians for CPT code 95971 and determined that the current work RVU of 0.78 appropriately accounts for the work required to perform this service. The specialty societies indicated that the survey 25th percentile work RVU was 0.80, similar to the current value and there is not compelling

evidence of a change in physician work at this time. The RUC agreed that 8 minutes pre-time, 20 minutes of intra-service time and 5 minutes immediate post-service time appropriately account for the work required to perform this service. The RUC compared code 95971 to key reference service 62370 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)* (work RVU = 0.90) and determined that 95971 requires slightly less physician work. For additional support, the RUC referenced MPC codes 95991 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional* (work RVU = 0.77) and 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75). **The RUC recommends a work RVU of 0.78 for CPT code 95971.**

95972 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour
The RUC reviewed the survey results from 60 physicians for CPT code 95972 and determined that the survey 25th percentile work RVU of 0.90 appropriately accounts for the work required to perform this service. The RUC agreed that 8 minutes pre-time, 23 minutes of intra-service time and 5 minutes immediate post-service time appropriately account for the work required to perform this service. The RUC compared code 95972 to key reference service 62370 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)* (work RVU = 0.90) and determined that both services require the same physician work. For additional support, the RUC referenced MPC code 74280 *Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon* (work RVU = 0.99) and CPT code 95938 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs* (work RVU = 0.86). **The RUC recommends a work RVU of 0.90 for CPT code 95972.**

Refer to CPT
The RUC recommends that CPT codes 95971, 95972 and 95973 be referred to CPT to address the entire family regarding the time referenced in the CPT code descriptors. Specifically, the descriptor for code 95972 specifies “first hour” but survey results indicate that the majority of physicians reporting this code take less than 30 minutes. Per CPT rules, since the midpoint of the specified time is not exceeded, the code is not reportable in the majority of circumstances under which the service is performed.

Secondly for CY 2016, the relevant specialties should submit a code change proposal to more definitely address the concern and make the codes more consistent with current

practice. The specialties anticipate two separate families; one for peripheral nerve root stimulators and another for spinal cord stimulators.

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.

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

Hyperbaric Oxygen Therapy (Tab 33)
Ethan Booker, MD (ACEP); Helen Gelly, MD (ACEP); Charles Mabry, MD (ACS); Mary Newman, MD (ACP)

The Relativity Assessment Workgroup identified these services through the CMS/Other Source – Utilization over 250,000 screen. In October 2013, the RUC noted that these services were never RUC reviewed but are frequently reported. The RUC recommended that these services be surveyed for physician work and develop direct practice expense inputs for the January 2014 RUC meeting.

The RUC reviewed CPT code 99183 *Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session* and determined that a work RVU of 2.11 appropriately accounts for the work required to perform this service. The specialty societies indicated that the survey conducted had methodological problems due to improper communication to possible survey respondents and therefore should not be used to recommend a work value for the surveyed code. The specialty societies recommended and the RUC agreed that a direct crosswalk to MPC code 90937 *Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription* (work RVU = 2.11) and 10 minutes pre-service, 40 minutes intra-service and 10 minutes immediate post-service time is appropriate. Both 99183 and 90937 describe a complicated patient that is previously known to the provider, is receiving a treatment familiar to the patient that lasts for several hours and in which a provider with specialty training for these particular services spends some but not all time bedside to the patient during the treatment. The specialty societies confirmed and the RUC agreed that 10 minutes of pre-service time is necessary for each session as the physician must review the patients interaction with multiple physicians, review changes in medication, review recent surgery or potential for surgery, assess the current blood sugar which is the main risk for hypoglycemic seizures while in the chamber and decide whether dietary supplements are necessary and ultimately responsible for conducting safety check list each session. **The RUC recommends a work RVU of 2.11 for CPT code 99183.**

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

XII. Practice Expense Subcommittee (Tab 34)

Doctor Manaker, Chair, presented the report of the Practice Expense Subcommittee

- Doctor Manaker thanked Doctor Neal, who chaired the Moderate Sedation Monitoring Time Workgroup, and the other members of the Workgroup for their work in collaboration with the radiology societies. The specialties presented documents outlining state licensure requirements and professional guidelines to the Workgroup. A letter of support from the American Nurses Association (ANA) was also submitted. Upon reviewing clinical practice guidelines and published literature provided by the specialty societies the Workgroup determined that an RN for patient monitoring is typical and medically necessary to monitor patients after moderate sedation.
- The PE Subcommittee reviewed the Moderate Sedation Standard Package. The PE Subcommittee considered whether or not a stretcher (EF018) (sometimes refer to as a gurney) is needed for patients receiving moderate sedation. After discussing with CMS and specialty society advisors it became clear that there is confusion because of the multiple ways that the stretcher might be used. The various scenarios for stretcher use are:
    - Consistent use throughout procedure – patient is wheeled in on the stretcher and remains on the stretcher for the entirety of the procedure. Patient recovers on the stretcher.
    - Short procedure, cannot be used by another patient – patient is wheeled in on the stretcher, but is moved for the procedure. The stretcher remains with the patient and the patient recovers on the stretcher.
    - Long procedure, can be used by another patient – patient is wheeled in on the stretcher, but is moved for the procedure. The linens are changed and the stretcher can be used for other patients. Patient recovers on a different stretcher.

  The PE Subcommittee is recommending that the RUC add a stretcher (EF018) to the standard package, as well as three scenarios for its use.
  The PE Subcommittee discussed the CMS proposal in the 2014 rule to cap the physician fee schedule at the lesser of the ASC or OPPS payment rate. This would have affected 211 CPT codes, many in pathology and radiology. CMS did not proceed in the final rule; however both we and CMS have to provide some rationale for these seeming discrepancies, to the public. In order to verify that our inputs are accurate the PE Subcommittee will review 63 of the 211 codes identified through the cap at the April 2014 RUC meeting. Other services from the list of 211 that have been recently reviewed will also be identified to CMS.
- PE Subcommittee member expressed interest in what the appeals process is for PE refinements. The PE Subcommittee will discuss this issue at the next meeting.
- The PE Subcommittee Chair discussed the issue of rising expenses for new technology. As part of the misvalued code initiative the practice expense is reviewed in addition to the work. Some of these codes are captured in the high volume or high expense screens because of very expensive equipment and disposable supplies. An unintended consequence of this review is that the cost of already high cost equipment and disposable supplies continues to escalate in the interim and is reflected in the direct practice expense inputs recommendations. There are many examples of this, such as the linac accelerator in the radiation treatment codes and the list of supplies and equipment in the GI codes. The equipment cost is increasing must faster than the physician fee schedule at a 1/2% a year. An unintended consequence of this review is that the cost of already high cost equipment and disposable supplies continues to escalate in the interim and is reflected in

the direct practice expense inputs recommendations. This is pulling PE RVUs from other codes in the fee schedule because the cost all of the disposable supplies and equipment remains fix, they are not rebased. There are a number of solutions, some of which CMS has proposed in the past and not moved forward with:

- Pricing from other sources such as the VA or the GAO acquisition cost list
- Propriety hospital acquisition cost list (unusable)
- Both inpatient and outpatient hospital cost report
- ASP/AWP pricing akin to what CMS has done for chemotherapy
- CMS or contractor re-pricing

If we fail to come up with some reasonable suggestions for rebasing these expensive devices and expensive supplies will continue to pull PE RVUs into these new codes and create distortions compared to old codes based on how recently a code is reviewed. Although purchasing power is variable a rebasing of all supplies and equipment would maintain relativity. The RUC Chair recommends that this issue is placed on the PE Subcommittee agenda for the April 2014 RUC meeting.

XIII. HCPAC Review Board (Tab 35)

Jane White, PhD, provided the Health Care Professionals Advisory Committee Review Board report:

- Dr. White indicated that the HCPAC reviewed and provided recommendations for six strapping procedures.

At the October 2013 meeting, the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that these services be surveyed for physician work and develop practice expense inputs.

Strapping Procedures (29200, 29240, 29260, 29280, 29520, 29530)

The American Physical Therapy Association (APTA) surveyed all six strapping services and the American Occupational Therapy Association (AOTA) participated only in the survey of CPT code 29280.

The HCPAC reviewed the survey results for codes strapping codes 29200, 29240, 29260, 29280, 29520 and 29530 and determined that all six strapping codes require the same work, time, intensity and complexity to perform as the key reference service 29540 *Strapping; ankle and/or foot* (work RVU = 0.39 and 7 minutes pre-service 9 minutes intra-service and 2 minutes immediate post-service time). The survey respondents indicated 0.40 median work RVUs and 0.39 work RVUs for the 25th percentile for all codes except CPT code 29520, in which survey respondents indicated a median work RVU of 0.49 and 25th percentile work RVU of 0.40. The HCPAC recommends crosswalking all six strapping codes to key reference service code 29540. The HCPAC noted that these services are typically reported with therapeutic services 97110 *Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* (work RVU = 0.45) or 97140 *Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes* (work RVU = 0.43). APTA and AOTA noted the pre-service and post-service times have been reduced and do not include any overlap in the work of the health care professional pre- and post-time associated with codes 97110 and 97140. APTA and AOTA also noted that 97110 and

97140 are "always therapy" services and if the strapping codes are reported with 97110 and 97140, the "always therapy" codes will be reduced under the MPPR. The HCPAC determined that the recommended times are appropriate and do not include any overlap in services.

The HCPAC also referenced CPT codes 29584 *Application of multi-layer compression system; upper arm, forearm, hand, and fingers* (work RVU = 0.35 and 18 minutes total time) and 97116 *Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)* (work RVU = 0.40 and 15 minutes total time) to support the recommended work RVU of 0.39.

The HCPAC recommends a work RVU of 0.39 and 7 minutes pre-service, 9 minutes intra-service and 2 minutes immediate post-service time for CPT codes 29200, 29240, 29260, 29280, 29520 and 29530.

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 PE Subcommittee adjusted the direct practice expense inputs to be consistent with the current standards, including adjusting the reference code 29540 and code 29550 which was not included in the review of work. The PE Subcommittee noted that the splint medical supplies are not reported separately, therefore were appropriately added. The inches of tape differ among the strapping codes because different lengths are necessary depending on which body site is being addressed. **The HCPAC accepted the direct practice expense inputs as modified by the PE Subcommittee.**

The RUC filed the HCPAC Review Board Report.

XIV. BETOS Workgroup (Tab 36)

- Doctor Charles Mabry, who was the acting Chair of the Workgroup for this meeting since Doctor Chad Rubin was unable to attend, gave the report of the BETOS Workgroup. Doctor Mabry gave a brief history of the Workgroup's actions so far. The Workgroup previously agreed that all codes assigned to the category of Procedures: Ambulatory should be reassigned to Procedures: Major or Procedures: Minor by the specialties that perform those services. In addition, all specialties were provided the opportunity to review and suggest reassignment of codes they deemed to be incorrectly assigned.
- The acting Chair noted that the Workgroup members continued several conversations about further enhancements to the BETOS classifications, including removing the Major/Minor categories and simply classifying procedures based on clinical categories. However, several Workgroup members voiced hesitancy in moving forward with broader changes because it is unclear how any revisions to BETOS will be used and if CMS would even accept them. CMS officials at the meeting indicated that CMS would be receptive to receiving Workgroup recommendations or suggestions for revisions to the file. The Workgroup agreed that a RUC letter should be drafted by the American College of Surgeons (ACS) for review and consideration by the BETOS Workgroup and then the RUC. If in fact the Agency is willing to consider changes, the Workgroup would then work with the specialty societies to provide more substantive changes to the classification

system apart from just the egregious errors. The Workgroup recommends that a letter be drafted, with the help of the ACS, to be submitted to CMS that outlines the current errors in the BETOS classification system, offers recommendations that have been discussed by the Workgroup, and urges CMS to request stakeholder input regarding possible revision of the BETOS product.

XV. Relativity Assessment Workgroup (Tab 37)

Marc Raphaelson, MD presented the Relativity Assessment Workgroup report the RUC.

- Review Action Plans

Work Neutrality
The RAW identified two CPT codes 57155 and 57156 due to the work neutrality impacts for codes reviewed in the CPT 2011 cycle. **The Workgroup recommends another review of claims data for 57155 and 57156 in 3 years.**

77001-77003 - Final Rule for CY 2014
CMS requested review of fluoroscopic guidance codes 77001-77003. The specialty societies indicated and the Workgroup agreed that there is no clinical reason why the fluoroscopic guidance should be shorter than the associated procedure. Imaging guidance may take more time than the procedure, for example, when it is difficult to place a needle precisely for a short procedure. Additionally, imaging guidance may be longer because the guidance necessary to advance the needle adjacent to a tendon sheath or epidural space takes longer than the subsequent intervention itself. The procedure service only measures the skin to skin procedure time. The Workgroup recommends that the times and values for these recently reviewed services, codes 77001-77003, are appropriate and no further action is necessary. The Workgroup also noted that CPT code 20610, which CMS specifically queried in the Final Rule, has already been identified and a new code to bundle this service with fluoroscopic guidance has been created and is to be reviewed at this January 2014 RUC meeting.

- **Re-Run of Previous Screens (based on new data)**

CMS/Other
In April 2013, AMA staff lowered the threshold to CMS/Other source codes with 2011 Medicare utilization of 250,000 or more, which results in 42 services, 13 of which have already been identified and were addressed in CPT 2014 and 10 of which are currently G codes. The Workgroup reviewed all 32 CPT codes at the October 2013 meeting and tabled review of the 10 G codes until January 2014 to review with its similar existing Category I code, if applicable.

The Workgroup noted that some of the G codes have Medicare utilization well over 1 million. The Workgroup recommended the following services be referred to CPT to possibly develop CPT Category I codes to define these services: G0101, G0179, G0180, G0181, G0283, G0438 and G0439. Both CPT codes and G codes exist to describe screening/diagnostic mammography. The Workgroup recommends that it analyze the

screening/diagnostic mammography services G0202, G0204 and G0206 and CPT codes 77057, 77056 and 77055 in September 2014, after the Proposed Rule is released and CMS addresses the RUC recommendation to convert the direct practice expense medical supply inputs from film to digital.

Site-of Service Anomalies
In February 2011, the RUC discussed the inpatient threshold percentage for re-reviewing codes regarding site-of-service and recommended maintaining the current 50% or less inpatient threshold. The RUC agreed and recommended that three consecutive years of data indicating 50% or less inpatient each year is appropriate in order to eliminate any annual fluctuations in the claims data.

AMA staff re-ran the site-of-service anomaly screen based on review of the 2010, 2011 and 2012 utilization data for services performed less than 50% of the time in the inpatient hospital setting, yet included hospital Evaluation and Management services within the global periods (99231, 99232, 99233 and 99238). At this time, no additional site-of-service anomalies were identified. **AMA staff will re-run the screen when 2013 final data are available.**

- **Additional Screens**
  In April 2013, the Relativity Assessment Workgroup had a robust discussion regarding additional proactive screens that may be reviewed to identify potentially misvalued services. The Workgroup tabled review of the data to determine possible future screens until the January 2014 meeting.
    - *Pre-time Analysis* – AMA staff reviewed codes prior to April 2008 with pre-time greater than pre-time package 4 *Facility - Difficult Patient/Difficult Procedure* (63 minutes) for services with 2012 Medicare Utilization over 10,000. The screen identified 21 services with more pre-service time than the longest standardized pre-service package. **The Workgroup reviewed these services and requests action plans from the specialty societies on how to address the pre-service time for these services. The Relativity Assessment Workgroup will review action plans in April 2014 for the following CPT codes: 15002, 15004, 15100, 15240, 20680, 22612, 23412, 25609, 27134, 27814, 29827, 34802, 34812, 34825, 36475, 36478, 39400, 47562, 63030, 63042, and 93641.**

    - *Post-Operative Visits*
      010-Day Global Codes
      AMA staff reviewed all 477, 010-Day global codes to determine any outliers. Many 010-day global period services only include 1 post-operative office visit. Staff pared down the list to 19 services with >1.5 office visits and 2012 Medicare utilization > 1,000. **The Workgroup reviewed the 19 services and requests action plans from the specialty societies to address/explain the office visits associated with these services. Possible action plan responses may be to support the number of post-op visits based on expert panel recommendation, or recommend revaluation, particularly for codes not recently valued.**

      090-Day Global Codes
      AMA staff reviewed all 3788, 090-Day global codes to determine any outliers. Based on 2012 Medicare utilization data, staff identified 10 services, reported at least 1,000 times per year that included more than 6 office visits. Additionally,

staff reviewed services which have more than one 99215 office visit. Based on 2012 Medicare utilization data, only one service (code 33235), reported more than 1,000 times per year, included two 99215 visits. **The Workgroup reviewed the 11 services and requests action plans from the specialty societies to address/explain the office visits associated with these services. Possible action plan responses may be to support the number of post-op visits based on expert panel recommendation, or recommend revaluation, particularly for codes not recently valued.**

One RUC member, stated his agreement with reviewing the post-operative visits, but more may need to occur to ensure relativity. Doctor Raphelson, indicated that identifying these post-operative visit outliers is one way in which the RAW may identify errors or services that are not correlating to other relative services. There may be other methods of identification, but these are the screens the RAW is working on currently.

- *Moderate Sedation performed by Another Provider the Same Day* Analysis
  The Workgroup identified 86 services in which anesthesia/moderate sedation services are performed by another provider the same day. The Workgroup discussed that reporting anesthesia services when the work and direct practice expense inputs for moderate sedation are already included in these services is problematic and Medicare and other payers. The Workgroup discussed the possibility of eliminating Appendix G and possibly creating add-on moderate sedation codes. However, an ad hoc Workgroup should be established to fully discuss and address this issue. **The Workgroup requests that CMS provide the frequency of sedation services provided by another physician on the same patient/same day for the facility and non-facility setting for services on the Appendix G list from the 100% Medicare claims file. The Workgroup recommends that a CPT/RUC Moderate Sedation Ad Hoc Workgroup be formed to review these data.**

- *Appendix G – Moderate Sedation Description of Work*
  The Workgroup requested identification of each procedure in Appendix G for which the work of conscious sedation is included in the intra-service work rather than the pre-service work. This was intended to identify services for which the physician time allocation and related expenses may be misvalued.

  AMA staff reviewed all 402 Category I codes in Appendix G for 2014. The moderate sedation description is not consistent and appears in the following areas for codes on Appendix G.

Moderate Sedation Description	**# of Codes**
Described in pre-time	111
Described in intra-time	119
Described in vignette	4
Administration not specified	107
Harvard/CMS Other source	36
Needs further review	25
Total	**402**

The Workgroup agrees that this analysis also has identified a large group of potentially misvalued codes. The Workgroup recommends that this issue also should be reviewed by a CPT/RUC Moderate Sedation Ad Hoc Workgroup. The Workgroup should determine whether a separate CPT code is needed to describe moderate sedation, review the services in which the description of administering moderate sedation is not described in the pre-time service description and revise Appendix G as required.

- **Outstanding Referrals**

  - *CPT Editorial Panel (77778, 77787, 77790)*
    CPT codes 77778, 77787 and 77790 were identified by Codes Reported Together 75% or more and the Joint Workgroup recommended that the specialty societies create a CCP to better describe the physician work performed for 77790 and to develop exclusionary parentheticals stating 77778 and 77790 not be reported together. This referred to the CPT Editorial Panel and the specialty societies were to complete by the 2015 CPT cycle. Additionally, the Joint Workgroup recommended that CPT code 77787 and 77300 be bundled no later than the 2015 CPT cycle as well. The specialty societies pursued this issue with CMS and CCI edits were established. **However, the Workgroup reviewed and reaffirmed the Joint Workgroup's recommendation and requests that the specialty societies submit parenthetical language to the CPT Editorial Panel as soon as possible.**

  - *CPT Assistant (97535)*
    CPT code 97535 was identified by the Codes Reported Together 75% or more and the Joint Workgroup recommended that the specialties create a CPT Assistant article. The specialties were asked to provide a detailed outline for the article to ensure that the content will be effective in negating the instances when the services 94770 and 97535 are reported on the same day. Specialty societies are working on an article for other codes in this family that were identified through this screen; however the specialties excluded CPT code 97535 in the article. **The Workgroup requests an action plan for 97535 to explain why this service has not been addressed through a CPT Assistant article.**

XVI. Research Subcommittee (Tab 38)

Doctor Scott Collins, Chair, provided a summary of the Research Subcommittee report:

- **The RUC reviewed and accepted the November and December conference call reports.**

- The American Physical Therapy Association (APTA) submitted a podcast to be used as educational material for codes that are currently pending CPT approval along with the standard RUC Survey Overview presentation. The Research Subcommittee approved use of the educational tool with modifications. The Research Subcommittee also requested AMA staff to develop a uniform webcast for use by all specialty societies.
- The Society of Thoracic Surgeons (STS) submitted a request that the RUC establish procedures for developing Reference Intensity Lists as well as develop and adopt a

standard methodology for reporting Intensity Surveys so that these results can be deemed valid and utilized in a manner consistent with RUC standards. This method was employed in the 2005 five year review and again in 2012 The Research Subcommittee recommends that the STS provide a sample of the survey instrument along with a more detailed presentation elaborating on the methodology utilized for the 2005 five year review and 2012 surveys, for further review in April 2014. The Background of CPT code 33533 is that STS has come up with multiple ways to value it, including an intensity survey, a building block methodology and utilization of the 25th percentile as well as a crosswalk. Regardless, CMS has rejected all recommendations and finalized the work value for 33533 at the current value of 33.75. Despite this, CMS has accepted the time data with an intraservice time of 158 minutes. The resulting calculated IWPUT of 0.096 is neither consistent with the evidence nor the values for the rest of the family. The Research Subcommittee recommends that the RUC flag CPT code 33533 as "DO NOT USE TO VALIDATE PHYSICIAN WORK".

- The American Congress of Obstetricians and Gynecologists (ACOG) requested review of vignettes on laparoscopic hysterectomy. The society had worked with the Research Subcommittee to develop vignettes and these vignettes were partially deemed to be not typical. At this meeting the society brought revised vignettes that more accurately reflect the typical patient to the Research Subcommittee and the will proceed to survey for the April 2014 RUC meeting. The Research Subcommittee also reviewed a request to conduct two proctored surveys and a random online survey. The Research Subcommittee will provide proctors for these surveys and as is customary the specialty society will need to present both the aggregated and separate data sets to the RUC at the April 2014 meeting.
- The Research Subcommittee reviewed the timeline developed by staff for RUC survey improvements and transition to the online RUC survey tool. We are entering the time to solicit comments from specialty advisors regarding modifications to the tool, survey intensity questions and the process. The ambitious goal is to have all RUC surveys conducted using the in-house tool by January 2015.
- The Research Subcommittee reviewed the standard survey intensity/complexity questions. There has been some concern that these questions cause survey fatigue or may not be useful. One of the ways they may not be useful is when multiple key reference services are selected and you have an aggregate intensity/complexity data point put together with only one key reference service to evaluate. There was a brief discussion of added additional data for more key reference services, but this was thought to be too cumbersome. Others have expressed they find these data to be useful in making comparisons across the RBRVS. The Research Subcommittee recommends that the RUC review all historical information regarding the formulation of intensity questions and definitions; review other options for determining work intensity; address these questions with CMS; and then determine the appropriate next steps. This review and discussion will continue into the April and future Research Subcommittee meetings, as necessary.
- The Research Subcommittee made some minor modifications to the reference service list guidelines. 1) Move the bullet point related to MPC codes to the top and eliminate," if appropriate"; and include 2) "recently" RUC validated codes.
- The Chair made two suggestions to specialty societies and staff. The Research Subcommittee does a lot of work between meetings and there are deadlines, please meet these deadlines so that recommendations can be high quality. The Research Subcommittee is happy to work with specialties to develop the best vignettes possible and review vignettes, but we depend on the specialty societies to provide an accurate estimation of what is typical.

XVII. Post Time Workgroup (Tab 39)

Doctor Przybylski, Chair, provided the report to the RUC

- Doctor Przybylski thanked the members of the Workgroup for their time, as well as RUC staff.
- The Workgroup completed work at the October RUC meeting however in December 2013, both the American College of Surgeons (ACS) and the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) expressed concern with the revisions, so the work was reviewed again at this meeting. The Workgroup addressed both revision of the pre-time work packages and creating the post-time work packages.
- In the 2013 Final Rule, CMS requested that the RUC consider assigning services that require only local anesthesia without sedation to the ‘‘no sedation/anesthesia care’’ pre-service time package, or that the AMA RUC create one or more new pre-service time packages to reflect the pre-service time typically involved in furnishing local anesthesia without sedation.
- At the October 2013 RUC meeting, the Post Time workgroup members discussed pre-time packages and concluded that package 5 should have 1 minute allocated for the administration of local anesthesia and package 6 should have 5 minutes for the administration of moderate sedation. The pre-service time packages were revised to reflect these changes
- In December 2013, both the American College of Surgeons (ACS) and the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) expressed concern with the revisions. Specifically, the specialty societies noted that Pre Time package 6 has never been understood to include IV sedation, has never been used for IV sedation in the office, and does not include any time for IV sedation related activities. Rather, it has been historically used for services requiring local/topical anesthesia, and has historically involved the addition of 5 minutes of scrub, dress, and wait pre time to account for the work of administering local/topical anesthesia.
- During the presentation of the report to the RUC, the Post-Time Chair acknowledged that several items were not described clearly, and therefore, not addressed by the workgroup. Specifically, it was noted that there are a limited number of RUC surveyed codes with Package 6 that include moderate sedation (only CPT code 35475 and 35476). By allocating the five minutes of time from (C) administer local anesthesia to (A) administer moderate sedation, Package 6 would no longer be applicable as written to account for prolonged local and/or topical anesthetic treatments that were formerly categorized as Package 6. Therefore, the RUC recommends the following: 1) Re-allocating five minutes back from (A) administer moderate sedation to (C) administer local anesthetic; 2) Rename Package 5 to “Procedure with Minimal Anesthesia Care (If no anesthesia care deduct 1 minute)”; 3) Differentiate Package 6 to Package 6A “Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect” and Package 6B “Procedure with sedation”; and 4) Add a footnote to Package 5 instructing removal of 1 minute if no anesthetic is applied. If a procedure is identified in which the typical patient is treated in a non-facility with moderate sedation, another Package may need to be developed. The Post Time workgroup recommends the Pre-Time packages with the noted modifications.

- The Workgroups also reviewed and considered modifications to current post time survey package. At the October 2013, the RUC approved standard post time packages as follows:

	7A Local/ Simple Procedure	7B Local/ Complex Procedure	8A IV Sedation/ Simple Procedure	8B IV Sedation/ Complex Procedure	9A General Anesthesia/ Simple Procedure	9B General Anesthesia/ Complex Procedure
Total Post-Service Time	**16**	**19**	**20**	**23**	**25**	**28**
Details:						
Dressing	2	2	2	2	2	2
Repositioning/ transfer of patient	1	1	1	1	1	1
Operative Note	5	5	5	5	5	5
Recovering/ Stabilization of patient	1	1	5	5	10	10
Communication with patient and/or family	5	5	5	5	5	5
Written post-operative note	2	5	2	5	2	5

However, the ACS recommended that "Simple" be modified to "Straightforward" to better align with the pre time packages. In addition, it was noted that time was not allocated for post-operative orders. Therefore, an additional category, "Post-Operative Orders and Order Entry" was created. The Workgroup members agreed that these packages are to be used as guidelines for determining post time and specialty societies may recommend additional time; however, post time should never exceed survey data unless the specialty society can provide sufficient justification.

Similar to the discussion related to pre-time, the Chair acknowledged that several items were not described clearly and therefore not addressed by the conclusion of the workgroup. Specifically, these include: 1) Rename "dressing" to "application of dressing", with footnote that this represents a simple dressing; 2) Rename "repositioning/transfer of patient" to "transfer of supine patient off table"; 3) Rename "recovering/stabilization of patient" to "monitor patient recovery/stabilization" and 4) Add an instructional foot note to indicate, "Advisors may request additional time for circumstances that require additional work beyond the type of work described". The Post Time Workgroup recommends the Post Time packages as revised below:

	7A Local Anesthesia/ Straightforward Procedure	7B Local Anesthesia/ Complex Procedure	8A IV Sedation/ Straightforward Procedure	8B IV Sedation/ Complex Procedure	9A General Anesthesia or Complex Regional Block/ Straightforward Procedure	9B General Anesthesia or Complex Regional Block/ Complex Procedure
Total Post-Service Time	**18**	**21**	**25**	**28**	**30**	**33**
Details:						
Application of Dressing[1]	2	2	2	2	2	2
Transfer of supine patient off table	1	1	1	1	1	1
Operative Note	5	5	5	5	5	5
Monitor patient recovery/ Stabilization	1	1	5	5	10	10
Communication with patient and/or family	5	5	5	5	5	5
Written post-operative note	2	5	2	5	2	5
Post-Operative Orders and Order Entry	2	2	5	5	5	5

Advisors may request additional time for circumstances that require additional work beyond the type of work described

[1] This represents a simple dressing

XVIII. Other Business

- A RUC member proposed that if a targeted survey is utilized using contact information provided from a company or manufacturer, an attestation should be required stating that the company of manufacturer provided no further communication regarding valuation or reimbursement. In addition the specialty society should provide the list to the Administrative Subcommittee. The RUC refers this issue to the Administrative Subcommittee to determine what action should be taken.
- The Facilitation Committee that reviewed CPT code 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* brought to the RUC's attention that CPT code 11981 *Insertion, non-biodegradable drug delivery implant* had the identical value and should be reviewed. It was not part of this review because it is a different family and was not identified as part of the high volume growth screen. The RUC refers CPT code 11981 to be vetted by the Relativity

Assessment Workgroup in April 2014. RUC staff will research additional data from outside the Medicare population.

- ACS submitted a letter to the RUC detailing the history of pre-service and post-service time and intensity. The letter explains that moving time from the intra-service period to the pre-service or post-service time can artificially increase IWPUT. The letter was referred to the Research Subcommittee to determine what action should be taken.
- The RUC discussed problems that arise from using reference codes in RUC review where the code has been previously reviewed by the RUC and CMS did not accept the RUC's recommendation. The RUC considered marking the codes as "not for use" in the RUC database, but ultimately decided that this would cause a larger problem and determined that flagging the codes as *codes valued by the RUC and valued differently by CMS*, or some version of that idea, over the last three cycles, would be the best course of action. The RUC discussed that these codes are already identified in the RUC database, but that this information should be prominently displayed on the general information tab. A timeline for implementation was not outlined, however the Chair advised the specialty societies to identify these codes in their SoRs for the April 2014 RUC meeting. The RUC will flag codes in the RUC database where CMS does not accept RUC recommendations for CPT 2012, 2013 and 2014.
- The Research Subcommittee receives requests from specialty societies to resurvey because of various problems with the survey results. Sometimes the survey data is submitted to the Research Subcommittee and sometimes it is not. A RUC member proposed that if a survey is conducted and then a request is made to not use the data, the collated data must be submitted to the Research Subcommittee for their review. The RUC referred this issue to the Research Subcommittee to determine what action should be taken.
- A RUC member proposed a policy that if a Specialty Advisor fills in for a RUC member during a RUC meeting they do not serve as an Advisor for the remainder of the CPT cycle. The RUC referred the proposal to the Administrative Subcommittee to determine what action should be taken.

Doctor Levy adjourned the meeting at 5:43pm on Saturday, February 1, 2014.

[i] https://www.novitas-solutions.com/policy/mac-ab/dl27547.html
[ii] Same as above

AMA/Specialty Society RVS Update Committee **Tab 34**
Practice Expense Subcommittee
January 29-30, 2014

Members Present: Scott Manaker, MD, PhD, FCCP (Chair), Albert Bothe, MD (CPT), James Blankenship, MD, Joel Brill, MD, Neal Cohen, MD, Thomas Cooper, MD, David Han, MD, Timothy Laing, MD, Alan Lazaroff, MD, Geraldine B. McGinty, MD, Eileen M. Moynihan, MD, Tye Ouzounian, MD, John Seibel, MD, W Bryan Sims, DNP, APRN-BC, FNP, Robert Stomel, DO, Thomas J. Weida, MD

I. Moderate Sedation Monitoring Time Workgroup

The Moderate Sedation Monitoring Time Workgroup met on December 4, 2013 via conference call to review information from the specialty societies regarding the clinical necessity of both the mandatory clinical staff and amount of time necessary for post-procedure monitoring. Upon reviewing clinical practice guidelines and published literature provided by the specialty societies the Workgroup determined that an RN for patient monitoring is typical and medically necessary for the 56 codes still under review by the Workgroup. The supporting documentation provided, as well as a letter of support from the American Nurses Association (ANA), are included as attachments to this report and will be included in the Workgroups recommendation to CMS.

Following the conference call the Workgroup voted by email on the following two issues:

- For the procedures in question, do you support use of an RN as the clinical staff type for post-procedure patient monitoring following 1 hour (15 minutes) of monitoring for moderate sedation, Yes or No?
- Do you support the final time recommendations for the codes reviewed (see attached spreadsheet), Yes or No?

The Workgroup members voted yes unanimously on both issues.

The Practice Expense (PE) Subcommittee offers the following recommendations to the RUC:

- **The 56 codes included in the review should be standardized to the clinical staff times listed in the attached spreadsheet.**
- **The 56 codes included in the review should maintain an RN as the clinical staff type for post-procedure monitoring not related to moderate sedation.**

II. Moderate Sedation Standard Package

Currently the moderate sedation standard package does not include a stretcher (sometimes refer to as a gurney). Many specialty societies that perform procedures with moderate sedation have indicated that a stretcher is needed and include it as a separate equipment direct PE input in their recommendations to the PE Subcommittee. The PE Subcommittee agrees that it is a necessary direct PE input and has determined that it should be added to the moderate sedation standard package. **The PE Subcommittee is recommending that the RUC add a stretcher (EF018) to the standard package, as well as three scenarios for its use.**

Scenarios for stretcher use:

- **Consistent use throughout procedure – patient is wheeled in on the stretcher and remains on the stretcher for the entirety of the procedure. Patient recovers on the stretcher.**
- **Short procedure, cannot be used by another patient – patient is wheeled in on the stretcher, but is moved for the procedure. The stretcher remains with the patient and the patient recovers on the stretcher.**
- **Long procedure, can be used by another patient – patient is wheeled in on the stretcher, but is moved for the procedure. The linens are changed and the stretcher can be used for other patients. Patient recovers on a different stretcher.**

Although the other equipment items in the standard package, *table, instrument, mobile* (EF027) , *ECG, 3-channel (with SpO2, NIBP, temp, resp)* (EQ011) and *IV infusion pump* (EQ032), would typically have the same number of minutes, equipment time for the stretcher should be based on the typical scenario for the service.

Additionally the RUC will be forming a joint CPT/RUC Workgroup to examine the implications of independent anesthesiologists (and CRNAs) performing anesthesia services for codes that previously were valued including moderate sedation. The Chair has been tasked with appointing representatives of the PE Subcommittee to serve on this Workgroup.

III. Outpatient Prospective Payment System and Ambulatory Surgical Center Cap

CMS requested broad feedback and recommendations regarding changes to the PE methodology. Pathology reported that 20% of their services are impacted by the OPPS/ASC Payment Cap. They explained that hospital cost analysis is not performed code by code as it is for the physician fee schedule and that hospital payments do not cover Pathology costs for these services. Interventional Radiology concurred with Pathology's statement and added that APC payments are not a reliable method for determining practice expense for all physician services. They continued that APC payments are an average that includes over- and underpayment in the hospital setting. Physicians' offices do not have the luxury of being able to absorb costs that exceed payment. CMS added that the Hospital Outpatient Panel (HOP), a federal advisory commission, is receptive to presentations from the specialty societies. Presentation guidelines can be found online and presentations can still be submitted in time for the March 2014 HOP meeting, regarding appropriate placement within APC groups. The Chair notes that two RUC members and a specialty society RUC advisor currently service on the HOP.

Following publication of the 2014 Final Rule, the RUC solicited feedback from the specialties societies regarding CPT codes potentially impacted by the OPPS/ASC Payment Cap. Specialty societies indicated an interested in re-reviewing or validating a recent RUC review, for 63 of the 211 codes identified through the cap. **The PE Subcommittee will review the codes identified by specialty societies, grouped by families, at the April 2014 RUC meeting and provide CMS with the recommendations as a sample subset of the codes impacted by the cap. Other services from the list of 211 that have been recently reviewed will also be identified to CMS.**

IV. Other Business

Direct PE Inputs Refinement

A PE Subcommittee member expressed interest in developing a formal appeals process for PE refinements. Currently the RUC solicits comments from the specialty societies for each refinement, collates the information, and submits the information to CMS. CMS assured the PE

Subcommittee that these comments are taken seriously and are considered in their rulemaking. **The PE Subcommittee will discuss an appeals process for PE refinements at the April 2014 RUC meeting.**

PPI Survey
A PE Subcommittee member suggested that CMS explore a new PPI survey

V. Practice Expense Recommendations for CPT 2015

Tab	Title	PE Input Changes (Yes or No)
4	Arthrocentesis	Yes Minor Modifications
5	Internal Fixation of Rib Fracture	Yes Minor Modifications
6	FEVAR Endograft Planning	No PE recommendation Carrier Priced
7	Endoscopic Hypopharyngeal Diverticulotomy	No 090 Global Standard
8	Colonoscopy through stoma	Yes Minor Modifications
9	Flexible Sigmoidoscopy	No
10	Colonoscopy	Yes Minor Modifications
11	Myelography	No PE recommendation Withdrawn from Review
12	Aqueous Shunt	No
13	Breast Ultrasound	Yes Minor Modifications
14	Radiation Treatment Delivery	Yes Minor Modifications
15	Bioimpedance Spectroscopy	Yes Minor Modifications
16	Brief Behavioral Assessment	No PE recommendation Refer to CPT

Tab	Title	PE Input Changes (Yes or No)
17	Negative Pressure Wound Therapy	Yes Minor Modifications
18	Selective Head and Total Body Hypothermia	No PE recommendation
19	End of Life Care-Advance Directive Plan	Yes Minor Modifications
20	Hormone Pellet Implantation	Yes Modifications/Handout
21	Injection for Knee Arthrography	No PE recommendation Not Surveyed
22	Endobronchial Ultrasound	No
23	Bronchoscopy-Computer Assisted	No
24	Laparoscopic Hysterectomy	No PE recommendation Postponed
25	Percutaneous Implantation of Neuroelectrodes	Yes Modifications/Handout
26	X-Ray Exams	No PE recommendation
27	CT Angiography-Chest	Yes Minor Modifications
28	Swallowing Function	No
29	Microdissection	Yes Modifications/Handout
30	Doppler Echocardiography	Yes Minor Modifications
31	Continuous Glucose Monitoring	No PE recommendation Postponed
32	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	Yes Minor Modifications

Tab	Title	PE Input Changes (Yes or No)
33	Hyperbaric Oxygen Therapy	Yes Modifications/Handout
35	Strapping Procedures (HCPAC)	Yes Modifications/Handout

AMA/Specialty Society RVS Update Committee **Tab 35**
Health Care Professionals Advisory Committee Review Board
January 30, 2014

Members: William Mangold, MD (Chair), Anthony Hamm, DC (Co-Chair), Jane White, PhD, RD, FADA (Alt. Co-Chair), Michael Chaglasian, Scott Collins, MD, Leisha Eiten, AuD, CCC-A, Mary Foto, OTR, James Georgoulakis, PhD, Stephen Levine, PT, DPT, MSHA, Eileen Moynihan, MD, Seth Rubenstein, DPM, W Bryan Sims, DNP, APRN-BC, FNP and Doris Tomer, LCSW

I. CMS Update

Doctor Edith Hambrick and Jessica Bruton from CMS attended the HCPAC meeting. Doctor Hambrick stated that CMS welcomes any comments from organizations if they missed the Final Rule comment period and would like to bring to CMS' attention. Organizations should contact Kathy Bryant or Doctor Hambrick if they wish to set up a meeting.

II. Primary Reviewers

Tony Hamm, DC, HCPAC Co-Chair, questioned the HCPAC if the assignment of primary and secondary reviewers was beneficial and if the HCPAC should continue this process as many primary reviewers did not submit comments for this meeting. The HCPAC discussed and determined that any comments received in advance are helpful to the presenting organizations and should be continued. A HCPAC member noted that perhaps only two or three primary reviewers should be assigned to make primary reviewers more accountable and encourage responses. The HCPAC noted that all HCPAC members may submit comments regarding relative value recommendation review, but the primary reviewers will be called upon first to address issues at the meeting. **The HCPAC will continue to assign primary reviewers for relative value recommendations.**

III. Relative Value Recommendation for CPT 2015:

Strapping Procedures (29200, 29240, 29260, 29280, 29520, 29530)

The American Physical Therapy Association (APTA) surveyed all six strapping services and the American Occupational Therapy Association (AOTA) participated only in the survey of CPT code 29280.

The HCPAC reviewed the survey results for codes strapping codes 29200, 29240, 29260, 29280, 29520 and 29530 and determined that all six strapping codes require the same work, time, intensity and complexity to perform as the key reference service 29540 *Strapping; ankle and/or foot* (work RVU = 0.39 and 7 minutes pre-service 9 minutes intra-service and 2 minutes immediate post-service time). The HCPAC recommends crosswalking all six strapping codes to key reference service code 29540. The HCPAC noted that these services are typically reported with therapeutic services 97110 *Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* (work RVU = 0.45) or 97140 *Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes* (work RVU = 0.43). APTA and AOTA noted the pre-service and post-service times have been reduced and do not include any overlap in the work of the health care professional pre- and post-time for 97110 and 97140. APTA and AOTA also noted that these are "always therapy" services and if the strapping codes are reported with 97110 and 97140, the "always therapy" codes will be reduced under the MPPR. The HCPAC determined that the recommended times are appropriate and do not include any overlap in services.

The HCPAC also referenced CPT codes 29584 *Application of multi-layer compression system; upper arm, forearm, hand, and fingers* (work RVU = 0.35 and 18 minutes total time) and 97116 Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing) (work RVU = 0.40 and 15 minutes total time) to support the recommended work RVU of 0.39.

The HCPAC recommends a work RVU of 0.39 and 7 minutes pre-service, 9 minutes intra-service and 2 minutes immediate post-service time for CPT codes 29200, 29240, 29260, 29280, 29520 and 29530.

Practice Expense

The PE Subcommittee adjusted the direct practice expense inputs to be consistent with the current standards, including adjusting the reference code 29540 and code 29550 which was not included in the review of work. The PE Subcommittee noted that the splint medical supplies are not reported separately, therefore were appropriately added. The inches of tape differ among the strapping codes because different lengths are necessary depending on which body site is being addressed. **The HCPAC accepted the direct practice expense inputs as modified by the PE Subcommittee.**

AMA/Specialty Society RVS Update Committee **Tab 36**
BETOS Workgroup
January 30, 2014

Workgroup members: Doctors Charles Mabry (Chair); Gregory Barkley; Albert Bothe; William Gee; Katharine Krol; Geraldine McGinty; Eileen Moynihan; Samuel Smith; Jennifer Wiler; George Williams; Edith Hambrick

I. Chair Review of Workgroup Progress

Charles Mabry announced that Doctor Chad Rubin was unable to attend the meeting and he would be acting as Chair for this meeting. Doctor Mabry briefly reviewed the progress of the Workgroup. The Workgroup previously agreed that all codes assigned to the category of Procedures: Ambulatory should be reassigned to Procedures: Major or Procedures: Minor by the specialties that perform those services. In addition, all specialties would also be provided the opportunity to review and suggest reassignment of codes they deemed to be incorrectly assigned. Last month specialty societies once again had the opportunity to review a file that included the collated specialty revisions to the BETOS classifications that were made initially over the summer.

II. Major/Minor Surgical Classifications

Now that most errors deemed egregious have been identified, Doctor Mabry opened up a discussion about whether additional changes could be made to further enhance the accuracy of BETOS. One area that may add greater accuracy is to remove the Major/Minor categories and simply classify procedures based on clinical categories. Several Workgroup members voiced hesitancy in moving forward with broader changes because it is unclear how any revisions to BETOS will be used and if CMS would even accept them. It was noted that while it is unknown whether or not there would be consequences to updating the BETOS classifications, there are also consequences to not updating the system, since it will continue to be used by researchers and other stakeholders regardless of refinements by the Workgroup.

CMS officials at the meeting indicated that CMS would be receptive to receiving Workgroup recommendations or suggestions for revisions to the file. The Workgroup agreed that a RUC letter should be drafted by the American College of Surgeons (ACS) for review and consideration by the BETOS Workgroup and then the RUC. The letter will outline the current errors in the BETOS classification system and offer recommendations that have been discussed by the Workgroup to address these concerns. The Workgroup agreed that it will be helpful to get feedback from CMS, and other stakeholders, prior to further review or recommendations for specific changes. If in fact the Agency is willing to consider changes, the Workgroup would then work with the specialty societies to provide more substantive changes to the classification system apart from just the egregious errors.

III. Next Steps

The Workgroup recommends that a letter be drafted, with the help of the ACS, to be submitted to CMS that outlines the current errors in the BETOS classification system, offers recommendations that have been discussed by the Workgroup, and urges CMS to request stakeholder input regarding possible revision of the BETOS product.

Members: Doctors Marc Raphaelson (Chair), Peter Smith (Vice-Chair), Margie Andreae, Amy Aronsky, Michael Bishop, Dale Blasier, Joel Brill, David Hitzeman, Walt Larimore, Larry Martinelli, Gregory Przybylski and Robert Zwolak.

I. Review Action Plans

57155 & 57156

In October 2013, AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2011 cycle. The total projected "source" work RVUs were 168,518,907 and the actual CPT 2011 work RVUs totaled 164,215,860. 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 recommends another review of claims data for 57155 and 57156 in 3 years.**

77001-77003 - Final Rule for CY 2014

As detailed in the CY 2013 final rule with comment period, CPT codes 77001, 77002 and 77003 were assigned CY 2013 interim final work RVUs of 0.38, 0.54 and 0.60, respectively, based upon AMA RUC recommendations. CMS agreed with the AMA RUC-recommended values but were concerned that the recommended intra-service times for all three codes are generally higher than the procedure codes with which they are typically billed. For example, CPT code 77002 has 15 minutes of intra-service time and CPT code 20610 has an intra-service time of only 5 minutes. CMS requested additional public comment and input from the AMA RUC and other stakeholders regarding the appropriate relationship between the intra-service time associated with fluoroscopic guidance and the intra-service time of the procedure codes with which they are typically billed.

The specialty societies indicated and the Workgroup agreed that there is no clinical reason why the fluoroscopic guidance should be shorter than the associated procedure. Imaging guidance may take more time than the procedure, for example, when it is difficult to place a needle precisely for a short procedure. Additionally, imaging guidance may be longer because the guidance necessary to advance the needle adjacent to a tendon sheath or epidural space takes longer than the subsequent intervention itself. The procedure service only measures the skin to skin procedure time. The Workgroup recommends that the times and values for these recently reviewed services, codes 77001-77003, are appropriate and no further action is necessary. The Workgroup also noted that CPT code 20610, which CMS specifically queried in the Final Rule, has already been identified and a new code to bundle this service with fluoroscopic guidance has been created and is to be reviewed at this January 2014 RUC meeting.

II. Re-Run of Previous Screens (based on new data)

CMS/Other

In April 2013, AMA staff lowered the threshold to CMS/Other source codes with 2011 Medicare utilization of 250,000 or more, which results in 42 services, 13 of which have already been identified and were addressed in CPT 2014 and 10 of which are currently G codes. The Workgroup requested that the

specialty societies submit an action plan for the October 2013 meeting for services not reviewed in the last 3 years or are not in the process of review. The Workgroup reviewed all 32 CPT codes and tabled review of the 10 G codes until January 2014 to review with its similar existing Category I code, if applicable.

The Workgroup asked CMS why G codes are developed. Doctor Hambrick indicated that they are developed for programmatic need and/or to address statutory requirements. The Workgroup noted that some of the G codes have Medicare utilization well over 1 million. **The Workgroup reviewed all 10 G codes. The Workgroup recommends the following services be referred to CPT to possibly develop CPT Category I codes to define these services: G0101, G0179, G0180, G0181, G0283, G0438 and G0439. Both CPT codes and G codes exist to describe screening/diagnostic mammography. The Workgroup recommends that it analyze the screening/diagnostic mammography services G0202, G0204 and G0206 and CPT codes 77057, 77056 and 77055 in September 2014, after the Proposed Rule is released and CMS addresses the RUC recommendation to convert the direct practice expense medical supply inputs from film to digital.**

Site-of Service Anomalies

In February 2011, the RUC discussed the inpatient threshold percentage for re-reviewing codes regarding site-of-service and recommended maintaining the current 50% or less inpatient threshold. The RUC agreed and recommended that three consecutive years of data indicating 50% or less inpatient each year is appropriate in order to eliminate any annual fluctuations in the claims data.

AMA staff re-ran the site-of-service anomaly screen based on review of the 2010, 2011 and 2012 utilization data for services performed less than 50% of the time in the inpatient hospital setting, yet included hospital Evaluation and Management services within the global periods (99231, 99232, 99233 and 99238). At this time, no additional site-of-service anomalies were identified. **AMA staff will re-run the screen when 2013 final data are available.**

III. Additional Screens

In April 2013, the Relativity Assessment Workgroup had a robust discussion regarding additional proactive screens that may be reviewed to identify potentially misvalued services. The Workgroup tabled review of the data to determine possible future screens until the January 2014 meeting.

1. *Pre-time Analysis* – AMA staff reviewed codes prior to April 2008 with pre-time greater than pre-time package 4 *Facility - Difficult Patient/Difficult Procedure* (63 minutes) for services with 2012 Medicare Utilization over 10,000. The screen identified 21 services with more pre-service time than the longest standardized pre-service package. **The Workgroup reviewed these services and requests action plans from the specialty societies on how to address the pre-service time for these services. The Relativity Assessment Workgroup will review action plans in April 2014 for the following CPT codes: 15002, 15004, 15100, 15240, 20680, 22612, 23412, 25609, 27134, 27814, 29827, 34802, 34812, 34825, 36475, 36478, 39400, 47562, 63030, 63042, and 93641.**

2. *Post-Operative Visits*

   010-Day Global Codes

   AMA staff reviewed all 477, 010-Day global codes to determine any outliers. Many 010-day global period services only include 1 post-operative office visit. Staff pared down the list to 19 services with >1.5 office visits and 2012 Medicare utilization > 1,000. **The Workgroup reviewed the 19 services and requests action plans from the specialty societies to address/explain the office visits associated with these services. Possible action plan responses may be to support the number of post-op visits based on expert panel recommendation, or recommend revaluation, particularly for codes not recently valued.**

090-Day Global Codes

AMA staff reviewed all 3788, 090-Day global codes to determine any outliers. Based on 2012 Medicare utilization data, staff identified 10 services, reported at least 1,000 times per year that included more than 6 office visits. Additionally, staff reviewed services which have more than one 99215 office visit. Based on 2012 Medicare utilization data, only one service (code 33235), reported more than 1,000 times per year, included two 99215 visits. **The Workgroup reviewed the 11 services and requests action plans from the specialty societies to address/explain the office visits associated with these services. Possible action plan responses may be to support the number of post-op visits based on expert panel recommendation, or recommend revaluation, particularly for codes not recently valued.**

3. *Moderate Sedation performed by Another Provider the Same Day* Analysis

The Workgroup requested that CMS provide data for each procedure in Appendix G (CPT Codes that include Moderate (Conscious) Sedation), to determine the frequency for conscious or other sedation performed by another provider the same day. These data would allow the Workgroup to identify services for which moderate sedation may not be typical and the resource inputs assumed by the RUC may be incorrect. To date CMS has not provided these data.

AMA staff economist, Kurt Gillis analyzed Appendix G with an enhanced version of the Medicare Claims 5% file. These data show the percentage of anesthesia services that are performed by different provider on the same patient/same day. These data indicate that another provider is typically reporting an anesthesia service for approximately 87 services in Appendix G. The Workgroup discussed that reporting anesthesia services when the work and direct practice expense inputs for moderate sedation are already included in these services is problematic and Medicare and other payers. The Gastroenterology specialty societies met with CMS to notify them that this is occurring prior to the restructuring of the entire GI family of endoscopy services. CMS indicated they were not interested in unbundling services at that time. The Workgroup discussed the possibility of eliminating Appendix G and possibly creating add-on moderate sedation codes. However, an ad hoc Workgroup should be established to fully discuss and address this issue. **The Workgroup requests that CMS provide the frequency of sedation services provided by another physician on the same patient/same day for the facility and non-facility setting for services on the Appendix G list from the 100% Medicare claims file. The Workgroup recommends that a CPT/RUC Moderate Sedation Ad Hoc Workgroup be formed to review these data.**

4. *Appendix G – Moderate Sedation Description of Work*

The Workgroup requested identification of each procedure in Appendix G for which the work of conscious sedation is included in the intra-service work rather than the pre-service work. This was intended to identify services for which the physician time allocation and related expenses, may be misvalued.

AMA staff reviewed all 402 Category I codes in Appendix G for 2014. The moderate sedation description is not consistent and appears in the following areas for codes on Appendix G.

Moderate Sedation Description	**# of Codes**
Described in pre-time	111
Described in intra-time	119
Described in vignette	4
Administration not specified	107
Harvard/CMS Other source	36
Needs further review	25
Total	**402**

The Workgroup agrees that this analysis also has identified a large group of potentially misvalued codes. The Workgroup recommends that this issue also should be reviewed by a CPT/RUC Moderate Sedation Ad Hoc Workgroup. The Workgroup should determine whether a separate CPT code is needed to describe moderate sedation, review the services in which the description of administering moderate sedation is not described in the pre-time service description and revise Appendix G as required.

IV. Outstanding Referrals

CPT Editorial Panel (77778, 77787, 77790)

CPT codes 77778, 77787 and 77790 were identified by Codes Reported Together 75% or more and the Joint Workgroup recommended that the specialty societies create a CCP to better describe the physician work performed for 77790 and to develop exclusionary parentheticals stating 77778 and 77790 not be reported together. This referred to the CPT Editorial Panel and the specialty societies were to complete by the 2015 CPT cycle. Additionally, the Joint Workgroup recommended that CPT code 77787 and 77300 be bundled no later than the 2015 CPT cycle as well. The specialty societies pursued this issue with CMS and CCI edits were established. **However, the Workgroup reviewed and reaffirmed the Joint Workgroup's recommendation and requests that the specialty societies submit parenthetical language to the CPT Editorial Panel as soon as possible.**

CPT Assistant (97535)

CPT code 97535 was identified by the Codes Reported Together 75% or more and the Joint Workgroup recommended that the specialties create a CPT Assistant article. The specialties were asked to provide a detailed outline for the article to ensure that the content will be effective in negating the instances when the services 94770 and 97535 are reported on the same day. Specialty societies are working on an article for other codes in this family that were identified through this screen; however the specialties excluded CPT code 97535 in the article. **The Workgroup requests an action plan for 97535 to explain why this service has not been addressed through a CPT Assistant article.**

V. Informational Data

The following reports were included as informational items:

- Referrals to the CPT Editorial Panel
- Referrals to the CPT Assistant Editorial Board
- Potentially Misvalued Services Progress Report
- Full CMS/Relativity Assessment Status Report

Members Present
Scott Collins, MD (Chair), M. Douglas Leahy, MD (Vice Chair), Gregory DeMeo, DO, (alternate to Sandra Reed, MD), James Georgoulakis, PhD, JD, David Hitzeman, DO, Charles Koopmann, MD, Walt Larimore, MD, Lawrence Martinelli, MD, Marc Raphaelson, MD, Christopher Senkowski, MD, Peter Smith, MD, Stanley W. Stead, MD, MBA and George Williams, MD

I. Research Subcommittee November 4, 2013 Conference Call Meeting Report

The Research Subcommittee report from the November 4, 2013 Conference Call is included in Tab 38 of the January 2014 agenda materials for approval by the RUC.

II. Research Subcommittee December 2, 2013 Conference Call Meeting Report

The Research Subcommittee report from the December 2, 2013 Conference Call is included in Tab 38 of the January 2014 agenda materials for approval by the RUC.

III. Specialty Society Request for Review of Education Material

American Physical Therapy Association (APTA)

The APTA submitted a podcast to be used as educational material for codes that are currently pending CPT approval. The Research Subcommittee noted that the standard RUC Survey Overview presentation will be utilized; however, the specialty society plans to delete five slides related to pre-, intra- and post time since these definitions are found in the survey instrument. **The Research Subcommittee recommends use of the educational tool with modifications. The specialty societies will submit the revised material for further review and approval. The Research Subcommittee also requested AMA staff to develop a uniform webcast for use by all specialty societies.**

IV. Specialty Society Request for Development of Survey Intensity Methodology

Society of Thoracic Surgeons (STS)

The STS submitted a request that the RUC establish procedures for developing Reference Intensity Lists as well as develop and adopt a standard methodology for reporting Intensity Surveys so that these results can be deemed valid and utilized in a manner consistent with RUC standards**.** This method was employed in the 2005 five year review and again in 2012, and validated by the RASCH method. Specifically, the average work intensity during a time period would be estimated and compared to average work intensities using a "Reference Intensity List" of other established codes by survey. The survey results would then be presented for evaluation in exactly the same fashion as in the current magnitude estimation surveys for physician work (Min, 25th, Median, 75th, Max). The members expressed concerns that the RASCH method may not be the most appropriate analysis tool unless the analysis is applied only to similar codes done by a single specialty. There was also agreement that it is easier to measure and compare intensity within a code family than across specialties. CMS staff indicated that although the STS values were accepted by CMS, they did not necessarily agree with methodology as discussed in the Final Rule. **The Research Subcommittee recommends that the STS provide a sample of the survey instrument along with a more detailed**

presentation elaborating on the methodology utilized for the 2005 five year review and 2012 surveys. In addition, AMA staff should provide background regarding earlier reviews of this intensity method and the CMS discussion within regulation.

The STS also requested that the RUC flag CPT code 33533 as "DO NOT USE TO VALIDATE PHYSICIAN WORK" in the RUC database. CMS finalized the interim value of 33.75 in the Final Rule for the 2014 Physician Fee Schedule, rejecting both the RUC and STS recommendations and maintaining the current value. This code was valued by the RUC and accepted by CMS in the 2005 5-year review using a mean STS database intraservice time of 151 minutes, and an IWPUT of 0.100 determined by survey shown above. CMS required review of this code in the 2011 Final Rule as a high-volume, high-expense code. This review was undertaken by STS using the same methodology as employed in its current valuation, which was based on STS database data from 2000-2004. The intraservice time was found to have increased from 151 to 158 minutes for 29,250 patients operated on from 2006-2010. Changes in patient characteristics from the database and recent publications indicated that the patient population had significantly changed as well, consistent with the increase in operative time, and compelling evidence for an increase in valuation was supported by the RUC. An intensity survey was performed.

The STS recommended an increase in value from 33.75 to 35.39 with all building block inputs remaining the same except for the increased intraservice time and a recommended IWPUT of 0.106, the median survey value. The RUC did not consider the Intensity Survey results, but instead recommended a direct crosswalk to 33510 Coronary artery bypass, vein only; single coronary venous graft with a work value of 34.98. In doing so, the RUC acknowledged that the work intensity had increased and was higher than that of 33510 (0.097). The recommendation results in a calculated IWPUT of 0.103. STS is concerned that this method of valuation departs from the established method whereby surveyed intensity is utilized to determine the intraservice work. A preferable method would have been to examine the 25th percentile intensity of 0.102 rather than the median value. This would have resulted in a work recommendation of 34.75, and been consistent with two established RUC methodologies:

1. The building block method with surveyed intensity and database derived physician time
2. The utilization of the 25th percentile survey results to correct for survey respondent outliers if the median value is not supportable

A crosswalk to 33510 to support this recommendation would have also been consistent with prior RUC actions.

Regardless, CMS has rejected all recommendations and finalized the work value for 33533 at the current value of 33.75. Despite this, CMS has accepted the time data with an intraservice time of 158 minutes. The resulting calculated IWPUT of 0.096 is neither consistent with the evidence nor the values for the rest of the family. **The Research Subcommittee recommends that the RUC flag CPT code 33533 as "DO NOT USE TO VALIDATE PHYSICIAN WORK".**

The Research Subcommittee also recommends that the RUC consider a broader discussion under new business to consider whether guidelines regarding flagging codes should be established when the RUC recommendation and CMS final rule value are discordant.

V. Specialty Society Request for Review of Vignettes

Laparoscopic Hysterectomy (58541-58544, 58570-58573)
American Congress of Obstetricians and Gynecologists (ACOG)

The Research Subcommittee initially reviewed revised vignettes during the November 4th conference call. At that time, the Subcommittee determined that the current vignettes were more appropriate and more accurately reflected the typical patient. ACOG proceeded to conduct a full RUC survey on the eight laparoscopic codes for presentation at the January 2014 RUC meeting. The specialty society received an inadequate response rate. In general, across the eight codes, the specialty society received 25 to 37 completed surveys; of those who indicated they have performed at least one procedure, 21 to 31 surveys were completed. In addition, some survey respondents indicated that the vignettes did not reflect the typical patient. ACOG requested permission to defer this tab until the April 2014 RUC meeting to once again review and revise the vignettes.

The Research Subcommittee reviewed the vignettes which were revised to reflect a standard age of 45, an obese patient, a defined gravida para and a patient with prior abdominal surgeries. There was consensus among the members that reference to obesity should be removed. In addition, the majority of members agreed that reference to prior abdominal surgeries, defined gravida and para and age should be removed. The members agreed that inclusion of these references can be leading. **The Research Subcommittee recommends the vignettes with the noted modifications.**

The Research Subcommittee also reviewed a request to conduct two proctored surveys and a random online survey. One proctored survey will be held on March 8 in Las Vegas and the second is scheduled on March 22 in Atlanta. AMA staff will work with the specialty society on confirming a proctor for both the March 8th and March 22nd surveys. **The Research Subcommittee recommends the use of the two proctored and one random survey. The specialty society will need to present both the aggregated and separate data sets to the RUC at the April 2014 meeting.**

VI. RUC Survey – 2014 Timeline

The Research Subcommittee reviewed the timeline developed by staff for RUC survey improvements and transition to the online RUC survey tool. Comments were made that the timeline is ambitious, but the Research Subcommittee will work aggressively toward meeting this timeline. It was also clarified again that the Qualtrics system will not include any data warehousing by the AMA. The specialty societies will receive another demonstration at both the April and September RUC meetings and should understand that their use of Qualtrics will be password protected. **The Research Subcommittee recommends the following timeline:**

DATE	ACTIVITY	STATUS	RESPONSIBILITY
October 5, 2013 (RUC Meeting)	Standard Survey Methodology Approved	Complete	Research Subcommittee
October 5, 2013 (RUC Meeting)	Adoption of new standards on number of survey respondents	Complete	Research Subcommittee
November 2013	One specialty society conducting RUC survey using Qualtrics tool for the January 2014 meeting	Complete	AMA Staff/ Specialty society staff
November 4, 2013 (Conf Call)	Approval of revised post-operative visit question format (w/n Qualtrics)	Pending RUC approval at the January 2014 meeting	Research Subcommittee
December 2, 2013 (Conf Call)	Determined that all survey questions must be	Pending RUC approval at the	Research Subcommittee

	completed to be considered a valid survey response (w/n Qualtrics)	January 2014 meeting	
December 2, 2013 (Conf Call)	Considered data trimming rules and agreed to the following: • Systematic trimming NOT incorporated in tool • Specialties to seek approval for any data trimming	Pending RUC approval at the January 2014 meeting	Research Subcommittee
December 2013	Development of standardized web-based tool to analyze data obtained from Qualtrics survey	Tool developed and will be modified as necessary based on specialty society feedback	AMA Staff working with outside vendor
January 2014 (RUC Meeting)	Review of timeline to transition to standardized survey tool	To be presented at the January 2014 RUC meeting	Research Subcommittee
January 2014 (RUC Meeting)	Review survey intensity questions to consider modifications w/n survey tool &/or use of data w/n RUC process: *initial discussion*	To be presented at the January 2014 RUC meeting	Research Subcommittee
January/ February 2014	Creation of detailed FAQs & Demonstration tools for Qualtrics tool	Pending	AMA Staff
February 2014	Identify 3-5 specialty societies who will conduct RUC surveys for the April 2014 meeting using Qualtrics tool	Pending	AMA Staff/ Specialty society staff
February/ March 2014	• Schedule Webinar on Qualtrics tool • Demonstration of Chain of Custody (specialty societies ownership of data) • Solicitation of comments from specialty society advisors & staff on suggested modification to intensity questions on survey tool & other survey enhancements	Pending	AMA Staff/ Specialty society staff Specialty society advisors

April 2014 (RUC Meeting)	Continue discussion and review survey intensity questions to consider modifications w/n survey tool &/or use of data w/n RUC process: *consideration of specialty society comments and information from other resources*	Pending	Research Subcommittee
April 2014 (RUC Meeting)	Face-to-face demonstration of Qualtrics tool & web-based survey analytic tool at the April 2014 RUC meeting with interested parties	Pending	AMA Staff/ Specialty society staff
June 2014	Identify additional specialty societies who will conduct RUC surveys using Qualtrics tool	Pending	AMA Staff/ Specialty society staff
August 2014	Solicit feedback from specialty societies conducting surveys using Qualtrics tool in 2014	Pending	AMA Staff/ Specialty society staff
September 2014 (RUC Meeting)	Face-to-face demonstration of Qualtrics tool & web-based survey analytic tool at the September 2014 RUC meeting with interested parties	Pending	AMA Staff/ Specialty society staff
September 2014 (RUC Meeting)	Research Subcommittee to review feedback from specialty societies conducting RUC surveys	Pending	Research Subcommittee
November 2014	**All surveys conducted by Qualtrics beginning with the January 2015 RUC meeting**	**Pending**	**AMA Staff/ Specialty society staff**

VII. RUC Survey-Intensity Questions

Currently, survey respondents are asked to compare intensity as it relates to time, mental effort and judgment, technical skill, physical effort and psychological stress in questions 3 and 4 for each code in the survey. On a conference call on December 2, the Research Subcommittee agreed that all survey questions should be mandatory. However, there was some discussion about whether or not every question that is currently on the survey is appropriate to maintain moving forward. During this discussion, it was brought up that perhaps the intensity/complexity questions should be reviewed by the Subcommittee to determine if modifications/deletions could be made to streamline the survey. There is a divergence of opinions on the usefulness of these data. Some have expressed their

frustration that these questions have the potential to overwhelm survey respondents at the end of a survey, especially when the survey contains multiple codes. Further, there was a concern that a single set of Intensity/Complexity measures derived from multiple comparisons (when the survey has multiple Key Reference Services selected) may be difficult to interpret. Others have expressed they find these data to be useful in making comparisons across the RBRVS, regardless of their perceived cumbersome nature. The Research Subcommittee had a broad discussion on whether or not these questions should be left as they are, completely deleted, or perhaps modified in some way to make these data even more useful. The Subcommittee questioned whether or not CMS would entertain revisions and consider a proposal to modify the intensity/complexity questions. **The Research Subcommittee recommends that the RUC review all historical information regarding the formulation of intensity questions and definitions; review other options for determining work intensity; address these questions with CMS; and then determine the appropriate next steps. This review and discussion will continue into the April and future Research Subcommittee meetings, as necessary.**

VIII. Reference Service Lists Guidelines

The Research Subcommittee reviewed and discussed the Reference Service List guidelines and determined that the following revisions are appropriate: 1) Move the bullet point related to MPC codes to the top and eliminate," if appropriate"; and include 2) "recently" RUC validated codes.

- **Include codes from the MPC list, ~~if appropriate~~**
- Include a broad range of services (i.e. 10-20 services) and their work RVUs. Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service
- Include codes that represent services on the list which are well understood and commonly provided by physicians in the specialty or subspecialty. Accordingly, a specialty society's reference service list may vary based on the new/revised code being surveyed
- Include similar or related codes from the same family or CPT section as the new/revised code (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)
- Include **recently** RUC validated codes
- Include codes with the same global period as the new/revised code
- Include several high volume codes typically performed by the specialty, if appropriate.

The Research Subcommittee recommends the Reference Service List guidelines as modified.

AMA/Specialty Society RVS Update Committee **Tab 39**
Post Time Workgroup
January 30, 2014

Members Present
Greg Przybylski, MD (Chair), M.Douglas Leahy, MD, Stanley W. Stead, MD, MBA, George Williams, MD, Peter Smith, MD

I. Review and consider modifications to current pre-time survey package
    - Letter from the American College of Surgeons
    - Letter from the American Academy of Otolaryngology - Head and Neck Surgery

In the 2013 Final Rule, CMS requested that the RUC consider assigning services that require only local anesthesia without sedation to the ‘‘no sedation/anesthesia care’’ pre-service time package, or that the AMA RUC create one or more new pre-service time packages to reflect the pre-service time typically involved in furnishing local anesthesia without sedation.

At the October 2013 RUC meeting, the Post Time workgroup members discussed pre-time packages and concluded that package 5 should have 1 minute allocated for the administration of local anesthesia and package 6 should have 5 minutes for the administration of moderate sedation. The pre-service time packages were revised to reflect these changes

In December 2013, both the American College of Surgeons (ACS) and the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) expressed concern with the revisions. Specifically, the specialty societies noted that Pre Time package 6 has never been understood to include IV sedation, has never been used for IV sedation in the office, and does not include any time for IV sedation related activities. Rather, it has been historically used for services requiring local/topical anesthesia, and has historically involved the addition of 5 minutes of scrub, dress, and wait pre time to account for the work of administering local/topical anesthesia.

After a detailed conversation, the workgroup concluded that it was never the intent to preclude procedures requiring local/topical anesthesia from package 6. These procedures would continue to be assigned to either package 5 or 6, depending on the work required. There are currently examples of services requiring local anesthesia with either package 5 or 6 assigned.

Rename Package 5 to “Procedure with Minimal Anesthesia Care (If no anesthesia care deduct 1 minute)”; 3) Differentiate Package 6 to Package 6A “Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect” and Package 6B “Procedure with sedation”; and 4) Add a footnote to Package 5 instructing removal of 1 minute if no anesthetic is applied

During the presentation of the report to the RUC, the Post-Time Chair acknowledged that several items were not described clearly, and therefore, not addressed by the workgroup. Specifically, it was noted that there are a limited number of RUC surveyed codes with Package 6 that include moderate sedation. By allocating the five minutes of time from (C) administer local anesthesia to (A) administer moderate sedation, Package 6 would no longer be applicable as written to account for prolonged local and/or topical anesthetic treatments that were formerly categorized as Package 6. Therefore, the workgroup recommends the following: 1) Re-allocating five minutes back from

(A) administer moderate sedation to (C) administer local anesthetic; 2) Rename Package 5 to "Procedure with Minimal Anesthesia Care (If no anesthesia care deduct 1 minute)"; 3) Revise Package 6 to Package 6A "Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect" and Package 6B "Procedure with sedation"; and 4) Add a footnote to Package 5 instructing removal of 1 minute if no anesthetic is applied. If a procedure is identified in which the typical patient is treated in a non-facility with moderate sedation, another Package may need to be developed. **The Post Time workgroup recommends the Pre-Time packages with the noted modifications.**

II. Review and consider modifications to current post time survey package
- Letter from the American College of Surgeons
- Letter from the American Academy of Otolaryngology - Head and Neck Surgery

At the October 2013, the RUC approved standard post time packages as follows:

	7A Local/ Simple Procedure	**7B Local/ Complex Procedure**	**8A IV Sedation/ Simple Procedure**	**8B IV Sedation/ Complex Procedure**	**9A General Anesthesia/ Simple Procedure**	**9B General Anesthesia/ Complex Procedure**
Total Post-Service Time	**16**	**19**	**20**	**23**	**25**	**28**
Details:						
Dressing	2	2	2	2	2	2
Repositioning/ transfer of patient	1	1	1	1	1	1
Operative Note	5	5	5	5	5	5
Recovering/ Stabilization of patient	1	1	5	5	10	10
Communication with patient and/or family	5	5	5	5	5	5
Written post-operative note	2	5	2	5	2	5

However, the ACS recommended that "Simple" be modified to "Straightforward" to better align with the pre time packages. In addition, it was noted that time was not allocated for post-operative orders. Therefore, an additional category, "Post-Operative Orders and Order Entry" was created. The Workgroup members agreed that these packages are to be used as guidelines for determining post time and specialty societies may recommend additional time; however, post time should never exceed survey data unless the specialty society can provide sufficient justification.

Similar to the discussion related to pre-time, the Chair acknowledged that several items were not described clearly and therefore not addressed by the conclusion of the workgroup. Specifically, these include: 1) Rename "dressing" to "application of dressing", with footnote that this represents

a simple dressing; 2) Rename "repositioning/transfer of patient" to "transfer of supine patient off table"; 3) Rename "recovering/stabilization of patient" to "monitor patient recovery/stabilization" and 4) Add an instructional foot note to indicate, "Advisors may request additional time for circumstances that require additional work beyond the type of work described".

The Post Time Workgroup recommends the Post Time packages as revised below:

	7A Local Anesthesia/ Straightforward Procedure	**7B Local Anesthesia/ Complex Procedure**	**8A IV Sedation/ Straightforward Procedure**	**8B IV Sedation/ Complex Procedure**	**9A General Anesthesia or Complex Regional Block/ Straightforward Procedure**	**9B General Anesthesia or Complex Regional Block/ Complex Procedure**
Total Post-Service Time	**18**	**21**	**25**	**28**	**30**	**33**
Details:						
Application of Dressing[1]	2	2	2	2	2	2
Transfer of supine patient off table	1	1	1	1	1	1
Operative Note	5	5	5	5	5	5
Monitor patient recovery/ Stabilization	1	1	5	5	10	10
Communication with patient and/or family	5	5	5	5	5	5
Written post-operative note	2	5	2	5	2	5
Post-Operative Orders and Order Entry	2	2	5	5	5	5

Advisors may request additional time for circumstances that require additional work beyond the type of work described

[1] This represents a simple dressing

Detailed Description of Pre-Service Time Packages (Minutes)

		FACILITY						NON-FAC		
		1A	1B*	2A	2B*	3	4	5**	6A	6B*
	Total Pre-Service Time	**20**	**25**	**25**	**39**	**51**	**63**	**8**	**23**	**23**
	CATEGORY SUBTOTALS									
A	Pre-Service Evaluation (IWPUT =0.0224)	13	19	18	33	33	40	7	17	22
B	Pre-Service Positioning (IWPUT = 0.0224)	1	1	1	1	3	3	0	1	1
C	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	6	5	6	5	15	20	1	5	0
	DETAILS									
A	History and Exam (Performance and review of appropriate Pre-Tests)	5	5	10	10	10	15	4	9	9
A	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2	2	2	2	2	4	1	1	1
A	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3	3	3	5	5	5	2	3	3
A	Communicate with other professionals	0	1	0	3	5	5	0	2	2
A	Check/set-up room, supplies and equipment	1	1	1	1	5	5	0	1	1
A	Check/ prepare patient readiness (Gown, drape, prep, mark)	1	1	1	1	5	5	0	1	1
A	Prepare/ review/ confirm procedure	1	1	1	1	1	1	0	0	0
A	Administer moderate sedation/observe (wait) anesthesia care	0	5	0	10	0	0	0	0	5
B	Perform/ supervise patient positioning	1	1	1	1	3	3	0	1	1
C	Administer local/topical anesthesia	1	0	1	0	0	0	1	5	0
C	Observe (wait anesthesia care)	0	0	0	0	10	15	0	0	0
C	Dress and scrub for procedure	5	5	5	5	5	5	0	0	0

* Indicates packages that contain moderate sedation
**If the procedure does not require local anesthesia, 1 minute should be removed from pre-service time

1A Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)
1B* Straightforward Patient/Straightforward Procedure (With sedation/anesthesia care)
2A Difficult Patient/Straightforward Procedure (No sedation/anesthesia care)
2B* Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)
3 Straightforward Patient/Difficult Procedure
4 Difficult Patient/Difficult Procedure
5 Procedure with minimal anesthesia care (If no anesthesia care deduct 1 minute)
6A Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect
6B Procedure with sedation

Additional Positioning Times for Spinal Surgical Procedures

SS1	Anterior Neck Surgery (Supine) (eg ACDF)	15 Minutes
SS2	Posterior Neck Surgery (Prone) (eg laminectomy)	25 Minutes
SS3	Posterior Thoracic/Lumbar (Prone) (eg laminectomy)	15 Minutes
SS4	Lateral Thoracic/Lumbar (Lateral) (eg corpectomy)	25 Minutes
SS5	Anterior Lumbar (Supine) (eg ALIF)	15 Minutes
SS6	Dorsal Lithotomy	5 Minutes

Additional Positioning Times for Spinal Injection Procedures

SI1	Anterior Neck Injection (Supine) (eg discogram)	7 Minutes
SI2	Posterior Neck Injection (Prone) (eg facet)	5 Minutes
SI3	Posterior Thoracic/Lumbar (Prone) (eg epidural)	5 Minutes
SI4	Lateral Thoracic/Lumbar (Lateral) (eg discogram)	7 Minutes

Notes:

*Roll-over cells for additional detail where available

***Straightforward procedure: Integumentary, Non-incisional endoscopy, natural orifice**

*For building block IWPUT purposes whenever the procedure is on Appendix G – (Summary of CPT codes that include moderate (conscious) sedation) the IWPUT should be .0224 for the administration of moderate sedation line item because the physician is responsible for the administration of conscious sedation. If the procedure is one where conscious sedation is not inherent the same line item should have an IWPUT of .0081.

*Additional time may be justified for a straightforward patient undergoing a straightforward procedure (Package 1B), if the procedure is performed under general anesthesia and the surveys support

Code	Description	Current RVW	FAC RVU	Pre Svc Pkg	Pre	Intra	Post Svc Pkg	Post	Total	IWPUT	Increment over base	Facilitation Rationale
Tab 10- Colonoscopy												
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed, (separate procedure)	3.69	3.36	1b	27	25	8a	15	67	0.10563	NA	Direct Crosswalk to KRC 31625 (wRVU= 3.36)
45379	Colonoscopy, flexible; with removal of foreign body	4.68	4.37	2b	33	35	8b	15	83	0.10047	1.01	45378 RVU + Foreign body RUC increment 1.01
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	4.43	3.66	1b	27	28	8a	15	70	0.10503	0.30	45378 RVU + biopsy RUC increment 0.30
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	4.19	3.67	1b	27	28	8a	15	70	0.10538	0.31	45378 RVU + submucosal injection RUC increment 0.31
45382	Colonoscopy, flexible; with control of bleeding, any method	5.68	4.94	2b	41	40	8b	15	96	0.10793	1.58	There is no RUC established increment for this procedure
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	4.69	4.17	1b	27	28	8a	15	70	0.12324	0.81	45378 RVU + hot biopsy RUC increment 0.81
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	5.3	4.67	2b	33	30	8b	15	78	0.12721	1.31	45378 RVU + snare RUC increment 1.31
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	4.57	3.87	2b	38	35	8b	15	88	0.08298	0.51	45378 RVU + dilation less than 30 mm RUC increment 0.51
4538X1	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	5.86	4.98	2b	33	35	8b	15	83	0.13247	1.62	45378 RVU + ablation RUC increment 2.13
4538X2	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)	5.9	5.50	2b	41	45	8b	17	103	0.09827	2.14	45378 RVU + stent RUC increment 2.14
4538X3	Colonoscopy, flexible; with endoscopic mucosal resection	NA	6.35	2b	33	45	8b	15	93	0.12214	2.99	45378 RVU + EMR RUC increment 2.99
4538X4	Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	NA	5.50	2b	41	40	8b	15	96	0.10793	2.14	There is no RUC established increment for this procedure
4538X5	Colonoscopy, flexible; with banding, (eg, hemorrhoids)	NA	4.30	2b	33	30	8b	15	78	0.10988	0.94	There is no RUC established increment for this procedure
45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	5.09	4.95	2b	41	45	8b	20	106	0.08456	1.59	45378 RVU + EUS RUC increment 1.59
45392	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	6.54	5.60	2b	41	60	8b	20	121	0.07425	2.24	45378 RVU + EUS with FNA RUC increment 2.24

AMA/Specialty Society RVS/Update Committee **Tab 10**
Facilitation Committee #1
Tab 10 - Colonoscopy

The Facilitation Committee met with the specialty societies and had a robust discussion surrounding the appropriate value for the colonoscopy diagnostic procedure CPT code 45378. The Facilitation Committee reiterated the concern around the RUC table that there is a lack of good crosswalk codes with 25 minutes of intra-service time between 3.40 and 3.60 work RVUs. Furthermore, the Committee agreed that the specialties' recommended work RVU of 3.60 did not adequately account for the total time reduction of 8 minutes from the current time to the survey time. The Facilitation Committee members noted that there were several CPT codes with comparable time with work RVUs around the 3.30 range. The Key Reference Service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) was reviewed and it was noted that while this service has 5 additional minutes of intra-service time (30 minutes) it has nearly identical total time to 45378, 70 minutes compared to 67 minutes. The Committee also reviewed CPT code 58555 *Hysteroscopy, diagnostic* (work RVU= 3.33) and noted that both services have identical intra-service time, 25 minutes, and similar total time. **Since CPT code 31625 was chosen as the key reference service, the Committee agreed to assign 45378 a work RVU of 3.36, a direct crosswalk to CPT code 31625.**

It was noted by the specialty societies that they did not agree with the recommended value of 3.36.

The attached spreadsheet lists the resulting work value recommendations for the colonoscopy series of codes, due to the base code adjustment.

AMA/Specialty Society RVS Update Committee **Tab 19**
Advance Care Planning
Facilitation Committee #2

Members Present: Doctors Larry Martinelli (Chair), Ron Burd, Anthony Hamm, DC, Sandra Reed, Christopher Senkowski, Peter Smith, Samuel Smith and Stan Stead.

9949X7 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate
The Facilitation Committee noted concern for potential over reporting of this service when only general advance directive services are conducted. The specialty societies noted and the Committee agreed that regular advanced directives may already currently be reported as part of an Evaluation and Management (E/M) service; however CPT code 9949X7 9949X8 includes separate advanced directive planning, palliative care and detailed advance care planning determinations.

The Facilitation Committee reviewed the survey results from 273 physicians and determined that the survey median of 1.50 work RVUs accurately account for the physician work required to perform this service. The Committee noted that the specialty society decreased the pre-service time from 10 to 5 minutes to account for any duplication when performed with an E/M. The Committee compared 9949X7 to key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient,* (work RVU = 1.50) and agreed that the physician work required to perform these services is the same. The Committee also compared 9949X7 to 90832 *Psychotherapy, 30 minutes with patient and/or family member* (work RVU = 1.50) which requires the same physician work and the same physician time of 5 minutes pre-service, 30 minutes intra-service and 10 minutes immediate post-service time. **The Committee recommends a work RVU of 1.50 for CPT code 9949X7.**

9949X8 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; each additional 30 minutes (List separately in addition to code for primary procedure)
The specialty societies indicated that the typical 9949X8 add-on service is a continuation of more than 45 minutes of discussion typically involving consensus of the patient and or multiple children/family members of the patient.

The Facilitation Committee reviewed the survey results from 273 physicians and determined that the survey median of 1.40 work RVUs and 30 minutes intra-service time accurately accounts for the physician work required to perform this service. The Committee compared 9949X8 to key reference service 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), noting 99292 requires more physician work. The Committee also compared 9949X8 to CpT code 90832 *Psychotherapy, 30 minutes with patient and/or family member* (work RVU = 1.50, if multiplied by 2 totals 60 minutes and 3.00 work RVUs) and determined that an hour of advance care planning, 9949X7 + 9949X8 = 2.90, is more intense than 60 minutes of 90832 because the last 30 minutes of psychotherapy is less intense than the physician work associated 9949X8. The Committee determined that a work RVU of 1.40 for CPT code 9949X8 appropriately places this service in the proper rank order relative to other similar services. **The Committee recommends a work RVU of 1.40 for CPT code 9949X8. The Committee recommends review of 9949X7 and 9949X8 in 3 years (September 2017).**

Referred to CPT Assistant
The Committee recommends that codes 9949X7 and 9949X8 be referred to CPT Assistant to educate physicians on how to code this service correctly.

AMA/Specialty Society RVS Update Committee
Facilitation Committee #3
Hormone Pellet Implantation

Members Present: J. Allan Tucker, MD (Chair), Dale Blasier, MD, Scott Collins, MD, Samuel Smith, MD, Geraldine McGinty, MD, Charles Koopmann, MD, Marc Raphaelson, MD

The Facilitation Committee discussed the physician work and time associated with CPT Code 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* and the appropriate work RVU relative to similar services, after the work RVU of 1.48 presented by the specialty societies was rejected by the RUC. The RUC expressed concern that maintenance of the current RVU of 1.48 was not supported by the reduction in time from 15/12.5/5 to 10/12/5. Although the Facilitation Committee acknowledged that the reduction in time may be a result of the creation of pre- and post-time packages since the code was last reviewed (February 2000), there was consensus among the members that a work RVU of 1.48 would over value this code. Therefore, the Committee recommended a direct crosswalk to CPT Code 11730 *Avulsion of nail plate, partial or complete, simple; single* (work RVU=1.10) with an identical intra service time of 12 minutes and similar intensity. The Committee also reviewed CPT Code 51705 *Change of cystostomy tube; simple* (work RVU= 0.90) and agreed that 11980 should be valued higher since this requires more physician work. The Committee also compared CPT Code 11980 to CPT Code 67810 *Incisional biopsy of eyelid skin including lid margin* (work RVU=1.18) and agreed that since this procedure requires slightly more physician work and intensity, it should be valued higher. **The facilitation committee recommends a work RVU of 1.10, a direct crosswalk to CPT code 11730 for CPT code 11980.**

AMA/Specialty Society RVS Update Committee **Tab 25**
Percutaneous Implantation of Neuroelectrodes
Facilitation Committee # 2

Members Present: Doctors Larry Martinelli (Chair), Allan Anderson, James Blankenship, Greg DeMeo, Michael Sutherland, Peter Smith, Samuel Smith and Stan Stead, Jane White.

64561 Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed

The Facilitation Committee compared 64561 to MPC code 52235 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)* (work RVU = 5.44 and 29 minutes pre-service, 45 minutes intra-service time and 20 minutes immediate post-service time) and recommends a direct crosswalk. This brings the IWPUT to 0.065 for 64561. For additional support the Committee referenced 33213 (090 global, work RVU = 5.53 and 46 minutes intra-service time). **The RUC recommends a work RVU of 5.44 and 22 minutes pre-evaluation, 5 minutes positioning, 45 minutes intra-service time and 19 minutes immediate post service time for CPT ode 64561.**

AMA/Specialty Society RVS Update Committee
Facilitation Committee #3
CT Angiography, Chest

Members Present: J. Allan Tucker, MD (Chair), Dale Blasier, MD, Scott Collins, MD, Charles Koopmann, MD, Walt Larimore, MD, William Fox, MD, Thomas Cooper, MD

The Facilitation Committee discussed the physician work and time associated with CPT Code 71275 *Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing* and its appropriate work RVU relative to similar services, after the work RVUs presented by the specialty societies were rejected by the RUC. The following is a summary of the facilitation committee's recommendation:

	71275
Pre Eval	5
Intra-Service	25
Post-Time	5
Total Time	35
RVU	**1.82**

71275 ***Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing***

The facilitation committee reviewed the survey results for CPT code 71275 and determined that a work RVU of 1.82, a direct crosswalk to 74177 *Computed tomography, abdomen and pelvis; with contrast material(s)* (work RVU=1.82) accounts for the physician work and time, with identical pre, intra and post time. To further support this value, the committee reviewed CPT codes 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU= 1.82) and determined that physician work and intensity are similar. Additionally the Committee noted that CPT code 74175 *Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing,* with identical pre, intra and post time was reviewed at the October 2013 RUC meeting and the RUC approved a value of 1.82. **The facilitation committee recommends a work RVU of 1.82, for CPT code 71275.**