

**AMA/Specialty Society RVS Update Committee  
Meeting Minutes  
January 29 – 31, 2015**

**I. Welcome and Call to Order**

Doctor Barbara Levy called the meeting to order on Friday, January 30, 2015 at 8:00 am.  
The following RUC Members were in attendance:

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

**II. Chair's Report**

- Doctor Levy welcomed everyone to the RUC Meeting.
- Doctor Levy welcomed the following Centers for Medicare & Medicaid Services (CMS) staff and representatives attending the meeting:
  - Sean Cavanaugh - Deputy Administrator and Director of the Center for Medicare
  - Ryan Howe –Deputy Director, Division of Practitioner Services
  - Edith Hambrick, MD – CMS Medical Officer
  - Steve E. Phurrough, MD – CMS Medical Officer

- Michael Soracoe – Research Analyst
  - Michael Brown – Consultant, Social & Scientific Systems, Inc.
  - Niranjana Kowlessar, PhD – Consultant, Social & Scientific Systems, Inc.
- Doctor Levy welcomed the following MedPAC Commissioners and staff:
  - Alice Coombs, MD – Commission Member
  - Julie Somers – Senior Analyst
- Doctor Levy welcomed the following researchers here to observe:
  - Armando Lara-Millan, PhD – Assistant Professor of Sociology at UC-Berkeley and a current Health Policy Fellow of the Robert Wood Johnson Foundation.
  - David Chan, MD, PhD – Assistant Professor of Medicine, Stanford School of Medicine
- Doctor Levy welcomed the following Rand Corporation researchers whom will be joining us by phone tomorrow to discuss the Rand report, including their methodology:
  - Barbara Wynn
  - Ateev Mehrotra
- Doctor Levy welcomed the following Contractor Medical Directors:
  - Charles Haley, MD, MS, FACP
  - Richard W. Whitten, MD, FACP
- Doctor Levy welcomed the following Member of the CPT Editorial Panel:
  - Frank Dubeck, MD – Panel Member Observer
- Doctor Levy welcomed new RUC members:
  - Margaret Neal, MD - College of American Pathologists
- Doctor Levy welcomed new RUC Alternate members:
  - Jimmy Clark, MD - College of American Pathologists
- Doctor Levy and the RUC said farewell to Doctor William Mangold, Jr, MD who has served on the RUC and HCPAC for nine years and previously provided the CMD updates. The RUC thanks Doctor Mangold for his long and distinguished service to the RUC.
- Doctor Levy laid out the following RUC established thresholds for the number of survey responses required:
  - Codes with  $\geq 1$  million Medicare Claims = **75 respondents**
  - Codes with Medicare Claims from 100,000 to 999,999 = **50 respondents**
  - Codes with  $< 100,000$  Medicare = **30 respondents**
  - Surveys below the established thresholds for services with Medicare claims of 100,000 or greater will be reviewed as interim and specialty societies will need to resurvey for the next meeting.
- Doctor Levy laid out the following guidelines related to confidentiality:
  - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement at the registration desk)
  - This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.
- Doctor Levy laid out the following procedural issues for RUC members:
  - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes
  - RUC members or alternates sitting at the table may not present or debate for their society
  - Expert Panel – RUC Members exercise their independent judgment and are not advocates for their specialty

- 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 invite 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.
  - The RUC votes 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
- Doctor Levy announced:
  - That all meetings are recorded for AMA staff to accurately summarize recommendations to CMS.
  - Only use Wi-Fi when necessary and limit to one device so they do not interrupt the work of the RUC.
  - Only save seats for your staff and only as many as you actually need. Please do not come into the room early and reserve seats. We have a lot of guests and we want to be sure that everyone has a place to sit.
  - To turn the ringers on your cell phones off or to vibrate

### **III. Director’s Report**

- The AMA appoints two seats to the RUC: the Chair and the AMA representative. The Board will consider those positions at their April board meeting. We have sent out a call for nominations to both of those positions as well as an alternate AMA representative position, which also serves as Vice-Chair. The deadline for those nominations is Friday, February 20<sup>th</sup>. The new RUC Chair, AMA Representative and Alternate AMA Representative will be announced at the April meeting.
- Please save the date for Friday April 24, 2015. The AMA will be hosting an event to honor Doctor Levy.
- In an effort to increase transparency, which the AMA and many of the specialty societies supported, CMS has changed some dates in order to include all of the issues that would impact the fee schedule every year in proposed rulemaking, giving the specialties a chance to comment over the summer. CMS agreed that this cycle will be a transitional year which means that everything that happened at the CPT meeting in October 2014 and this meeting will be addressed in proposed rulemaking. For the issues coming out of the February 2015 CPT meeting next week and the RUC April 2015 meeting, CMS will publish their decisions as interim, as they normally do, in the Final Rule with public comment available in November 2015 to be implemented on January 1, 2016. Because of this transition the timeline is abbreviated and there will only be two meetings associated with the CPT 2017 cycle. This will be the May 2015 and October 2015 CPT Editorial Panel meetings. November

will no longer be the last date of submission to CPT for any given cycle, this last date of submission will be moving to July 8<sup>th</sup>. In order to accommodate the February 10<sup>th</sup> submission date we have moved up the RUC meeting a few weeks to mid-January starting in January 2016 and moving forward. In order to meet the February 10<sup>th</sup> deadline for this meeting we will be sending you the draft recommendations by next Thursday and you will only have four or five days to review that material.

**IV. Approval of Minutes of the September 18-20, 2014 RUC Meeting**

**The RUC approved the September 2014 RUC Meeting Minutes as submitted.**

**V. CPT Editorial Panel Update (Informational)**

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

- Doctor Bothe welcomed CPT staff Desiree Rozell and Doctor Dubeck as an observer from the CPT Editorial Panel at this meeting. In a reciprocal fashion, Doctor Burd will be attending the CPT meeting next week. We do this in order for both the RUC and CPT to have an understanding of what the other is doing.
- The change in members of the CPT Assistant Editorial Board was announced at the last CPT meeting. Doctor Burd (Psychiatry), Doctor Roddy (Vascular Surgery) and Doctor Bradley (Pediatrics) will be joining the board.
- There were 72 tabs on the CPT Editorial Panel's agenda at the last meeting. In addition, there will be a report on the Moderate Sedation Workgroup, a report from the Workgroup on Literature Requirements (the evidence basis that supports proposals for CPT); we will also see a final draft of the CCP application form for new codes. Some redundant questions were removed and questions that align with RUC issues were added in order to streamline the process from CPT to RUC. Finally, there is a proposal in line with the film to digital transition, to alter 10 codes that had the word film in the descriptor.

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

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

- CMS Administrator Marilyn Tavenner will be leaving sometime soon. Her replacement will be Andy Slavitt who will serve as Acting Administrator.
- There have also been some changes in the Hospital and Ambulatory Policy Group which is where the Physician Fee Schedule sits in the CMS hierarchy. Kathy Bryant, Director of Practitioner Services will be transferring to the Office of Legislation. John McInnes, MD, JD, whom some of you know from the Division of Outpatient Care, will be coming to the Division of Practitioner Services as the Acting Director. Ryan Howe will continue as the Deputy Director of Practitioner Services.
- If you have anything to discuss with CMS in regard to 2016 rulemaking, please do so now. CMS is working on rulemaking now.
- Sean Cavanaugh thanked the RUC for giving him the opportunity to observe and learn about the RUC process.

## **VII. Contractor Medical Director Update (Informational)**

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

- There are eight A/B MAC contracts serving twelve jurisdictions:
  - Cahaba was awarded jurisdiction J, Alabama, Tennessee and Georgia. There was a protest that was evaluated by the GAO and it was dismissed. Part of the contract is that Cahaba has the national contract for histocapability laboratories.
- Changes in CMDs
  - Doctor Greg McKinney previously with Cahaba is now on a boutique contract at National Government Services.
  - Doctor Paul Deutsch retired last year, but is now back to work for one of the recovery audit contractors.
  - Doctor Bernice Hecker previously with Noridian has retired.
  - Novitas has hired Doctor RaeAnn Capehart as their new CMD.
  - WPS has hired Hillary Bengal.
- The CMD Directory is available and is routinely one of the handouts distributed at the AMA's CPT and RBRVS Annual Symposium in November.
- There is a protest regarding the work of the recovery auditor contractors (RACs). This should be resolved by the middle of the summer and in the meantime they are continuing with their work on a limited scale. They are prohibited from examining inpatient hospital claims with the two midnight rule admission rule. The prohibition expires on March 31<sup>st</sup>.
- ICD-10 is scheduled to go into effect in October.
- A RUC member asked about RACs being overwhelmed with volumes of appeals and if anything was being done to streamline the process.
  - Most of the A/B MACs and the QICs are fairly timely in their appeals process, despite the large volume. CMS also offered a resolution for all level of care determination appeals, one time settlements of 68% of the face value. It settles the claim completely and many hospitals took CMS up on this settlement. Appears that the backlog is shrinking.

## **VIII. Washington Update (Informational)**

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

- Because of time constraints this presentation was abbreviated; please see the Washington Update slides for more information
- Penalties and regulatory burden
  - There are limited resources for CMS to implement these penalties and regulations so much of it is being shifted to contractors. This makes it hard to find out what is happening.
  - Slide seven outlines what we are focusing on this year. The repeal and replace bill would resolve some of these issues and the penalties would be smaller. Some of the issues could be addressed in a short term patch.
- Meaningful Use
  - Only three percent of physicians have been able to meet stage two requirements.
  - Some areas that are especially problematic that we are asking for compromise on:

- Requirement of patients to use portals (even if you have them, you cannot make patients use them) – We have asked to make this voluntary
- Interoperability requirement for transitional care - We have asked to make this voluntary
- 100 percent compliance to meet the requirements – we are asking for 75 or 80 percent compliance.
- 365 days a year – we have asked for shortening this to 90 days and CMS has announced that they will do this.
- We have asked for MU and PQRS to be interchangeable, so if you report for one you have automatically reported for the other.
- PQRS has become much harder to comply with.

## **IX. RAND Study – Developing a Model to Validate the RBRVS Work Values**

Barbara Wynn and Ateev Mehrotra, Rand Corporation provided a report on the recent Rand study entitled *Developing a Model to Validate the RBRVS Work Values*:

- RAND is a non-profit research organization committed to conducting objective, independent analysis to address public policy challenges.
- Barbara Wynn has been at Rand for 15 years, after 24 years at CMS. Most of her research has been in health care delivery and financing issues. At CMS she was involved in some of the initial implementation of the RBRVS and then later with the practice expense component.
- Ateev Mehrotra is a Physician and Researcher. He practices at Beth Israel Deaconess Medical Center and is a Professor at Harvard Medical School in the Department of Health Care Policy.
- The other Rand Researchers involved are Lane Burgette – Statistician, and Andrew Mulcahy – Health Economist
- CMS asked RAND to develop a model to validate the physician work RVUs, using available databases. RAND's is only one of the strategies; the Urban Institute is looking into the feasibility of collecting primary data.
- The model results could be used to provide an independent estimate of work RVUs, identify potentially misvalued codes and to provide information on individual work components.
- The report is extremely technical, but today given the time constraints we only have time for a high level overview.
- The research focused on 3,179 surgical procedures (as defined by CPT) and medical procedures often performed in an OR setting. This is key to the time element.
  - There was no external time data for other types of services, which raises questions about the ability to maintain relativity and generalizability.
  - Approach was to collect data from large databases (Medicare and non-Medicare) on characteristics for each procedure.
  - Particular focus on intra-service time for single procedures. Used this time to build prediction models to estimate the total work RVU.
- Overview of Steps
  - Use reverse building block methodology (BBM) to derive current RVUs for individual work components using the CMS time file values
  - Estimate intra-service times using external data
  - Predict work RVUs for individual work components and total work RVUs
  - Compare RAND estimates to current work values

- Draw on technical expert panel (several members had extensive involvement with the RUC) and clinical input at various stages, which does not mean that these experts endorse RAND's findings.
- Key Challenge is Lack of Gold Standard
  - The starting point was the total work RVUs under the current system and used the CMS time file for the other components.
  - For pre/immediate post-service work: Use CMS time estimates and standard intensity factors
  - For post-operative E&M Work: Use CMS visit counts and E/M work to estimate post-operative E/M work
  - Need to derive intra-service work using total work estimates and reverse building block method (BBM)
  - The graphic shows the dependent variables were the derived values using CMS estimates and reverse building block. The independent variables were the RAND time estimates and the other procedure characteristics the researchers developed. The predicted results were then added back up using the BBM method to estimate total work. In addition estimated total work without using BBM.
- The time it takes to perform the service or intra-service time was used as key variable in prediction models. Other variables used in prediction models are:
  - Other characteristics of procedure
    - Code grouping
    - Body system
    - Global period
    - Risk level
    - Laparoscopic or thoracic procedure
  - Patient and service complexity
    - Co-morbidities
    - Length of stay
    - ICU days
    - Age
    - Gender
    - Major complications
    - Mortality rate
  - Intensity – Goal to operationalize the RUC's definition of the components of intensity used in the RUC survey, but found that the variables RAND constructed did not have a high explanatory power. It is unclear if this is due to bad proxies or the intensity factors derived from BBM being too variable.
    - Malpractice risk
    - Years of training
    - Urgency of decision making
- There are three key issues that were used to structure the models
  - Issue A: BBM vs. single prediction model
    - Information on each component and single prediction model is more consistent with magnitude estimation
  - Issue B: Typical vs. all place of service
    - Thought that an average across all settings may be more accurate than the typical setting
  - Issue C: How to value intra-service intensity (IWPUT)
    - Most critical issue
    - RAND found shorter intra-service time than in CMS time file and had to figure out how this effects intensity

- Assuming shorter times increases intensity is an increase in mean IWPUT
  - Assuming shorter times reduce intra-service work means no increase in the mean IWPUT
  - RAND modeled these two assumptions as well as a blend
- Estimating intra-service time
  - Intra-service time is the key variable in prediction models
  - No single available data source provides surgical time so used two data sources
    - Medicare anesthesia times
    - Procedure times from ambulatory centers in NY
  - Transformed anesthesia and procedure times into intra-service times
  - Estimated times for single procedures only
  - Validated RAND intra-service time estimates using several data sources including NSQIP
- RAND compared estimates to NSQIP data and determined they are highly correlated, if anything RAND estimate is higher.
- Compared RAND times to CMS times and they are consistently shorter across all procedures
- Estimating Pre- and Immediate Post-Service Work
  - Separately estimated work for the three sub-components of pre-service work and immediate post-service work
  - Fit regression models to estimate length (in minutes) for each activity:
  - Used coefficients from the models to estimate time, which we then multiplied by the standard intensity factors to estimate work for each activity
  - Increases weighted average work RVUs for pre/post by 11 percent
  - Highest increases in procedures that are short, have 000-day global period, or the typical POS is office
- Estimating Post-Operative Visits
  - No external data on number of E/M visits provided in global period
  - Dependent variable corrected number of E&M visits in CMS data
    - Corrected inpatient count based on length of stay and misclassification of procedures as inpatient when typical POS ambulatory setting
    - No adjustment to total work so E/M corrections are offset by changes in intra-service work
  - Independent variables are RAND intra-service times and other procedure characteristics
  - Used coefficients from regression model to estimate total post-operative work
- RAND post-operative estimates on average are lower than CMS estimates by about 10%, RAND determined weighted and unweighted. The weighted results in this scenario are services performed more frequently in the Medicare population.
- Estimating intra-service work (ISW) options: Mean intra-service work RVUs relative to CMS values – unweighted results
  - Model 1a assumes shorter times increase intensity (IWPUT): 10% increase
  - Model 1b is a blend of Models 1a and 1c: somewhere in middle
  - Model 1c assumes shorter times reduce ISW work: 15% reduction
- Estimating total work
  - We used the BBM to combine the estimates for Models 1 and 2
  - We also estimated total work directly (model 3)
    - Dependent variable: current RVUs with constraints on statistical outliers and excess inpatient visits



- Independent variables are the same as for ISW: RAND intra-service times, procedure and patient characteristics and intensity proxies
  - Used the coefficients from the prediction model to estimate total work for each service
  - Mean total work RVUs relative to CMS values – unweighted results.
    - Many of the models are total estimates are very similar to CMS time file
    - 1b and 1c in particular, there is significant reduction in total work
- Major limitations
  - If there is bias in the CMS time file there is bias in RAND results, in particular the current debate about post-operative visits. If there are too many visits in the time file than the RAND model would correspond with that.
  - Because most independent data is based on Medicare administrative data, models may not generalize well to commercial populations.
- Clinical Input
  - Four specialty-specific clinical panels
    - Preliminary input on clinical validity of results
    - Comparison of RAND model and current estimates
  - Several themes
    - Difficulty in task – for small differences difficult to determine which is more accurate
  - Bias because lack data on office-based procedures
    - If typically performed in the office and it is done in the OR, this would be an unusual case and would therefore take longer
    - In general procedures in the office take longer as the patient would not be under anesthesia and the physician has to be much more responsive to patient needs
  - Procedures where concept of intra-service time different
    - Example is Mohs procedure
  - Aspects of intensity not captured in our models
    - Example is greater intensity of performing procedure on face versus other parts of body
  - Why is intra-service intensity continuous scale?
    - Clinicians tended towards intensity buckets
- Summary of Key Findings
  - RAND intra-service time estimates typically shorter than the current CMS estimates
  - Corrections reduce post-operative E&M visit work 10%
  - Total work across most models is similar but important differences for some procedures
  - Model differences largely attributable to assumptions regarding how shorter times affect procedure intensity
  - Unweighted average impact on total RVUs is greater than the volume-weighted average across procedures
- Potential Refinements to the Model
  - Develop a gold-standard estimate for intra-service work for ~200 procedures to calibrate models
  - Improve RAND time estimates by adding time data for office-based procedures
  - Obtain clinical input on how to improve models
  - Expand the model to include other types of services

- Questions and Answers
  - **Q1:** You mentioned that some variables were more important than others. Which variables other than time were most important?
    - **A:** The exact amounts are the coefficients of the regression analysis, which can be found in the report. One variable that was important was code groupings. We wanted to use data that would be clinically coherent and reflective of the work required. We used APC groupings for everything other than inpatient only procedures. These are outpatient groupings; however we found that it was a strong predictor and that the concept of resource intensity was there. Clinical Body systems and risk level were also important variables. For risk level we used the least resource intensive environment in which the service can be provided. The variables of laparoscopic or thoracic procedure and the intensity measures were not as significant. It was surprising that variables such as years of training, urgency of decisions making and mortality rate had very little impact after controlling for the other variables.
  - **Q2a:** Your three models seem to indicate that you are unsure of the relationship between intra-service work and intensity. Hsiao's early work indicated that they are not independent variables. This seems to be best demonstrated in your model 1b, is that correct?
    - **A:** We certainly did not find a way to value intensity differently, so that would be correct. In terms of the question of which model shows they are independent variables, we do not have an optimal model for that. We have not identified other research that investigates the relationship between intra-service work and intensity other than Hsiao's use of magnitude estimation. We were not able to operationalize intensity in a way that had a good explanatory power. The relationship in the CMS time files indicates that they are not independent.
  - **Q2b:** The RUC member indicated that the IWPUT are derived values in the CMS time file and when treated as independent variables it could be a compounding error for your report.
  - **Q3:** You mention calibrating your model with 200 services. Have you determined which services that will be, because it may help the RUC to determine which services are most important going forward?
    - **A:** No we have not
  - **Q4:** The E/M services were not looked at and they are the major focus of the Medicare Fee Schedule. It raises the concern that relatively may not have been maintained if those services are not included.
    - **A:** That is a valid concern. The issue of maintaining relativity is discussed in the report. We can say that we maintained relativity among the services that we studied, but we have not maintained relatively with the services that are outside the scope of the study. The issue of relativity would become more paramount dependent on how this study is used.
  - **Q5:** There is about a 10 percent reduction in the E/M visits. Have you included a day of surgery visit in the length of stay or only the post-operative length of stay?
    - **A:** For the post-operative we have included the day of the surgery, there was a visit allowed.
  - **Q6:** The coronary artery bypass grafting codes have about 30 minutes more time in your model than in the CMS database and the CMS database is based on STS data, which we consider to be fairly accurate. What might be different about that type of procedure and why might it be different in your model?

- **A:** We do not know the reason for larger discrepancies between some services over others, however we have created a framework and if other data sources become available, our framework would allow for numerous databases to be brought in. We hope this would provide richer clinical data so the times could continuously be refined.
- A RUC member brought up that there is inherent bias because of lack of data and we do not want the regulators to believe that because this is a formula, it is correct. The inputs determine the validity of the data, not just that it is a formula. We need better inputs to have accuracy.
- **Q6:** What codes would you flag as potentially misvalued from this report?
  - **A:** You could compare the two numbers and if they are sufficiently different that might raise further concerns. You would have to determine what that threshold would be. There are a large number of procedures with around a 20 percent difference.
- **Q7a:** Please explain how you used the Anesthesia data using the Silber technique to determine the intra-service time.
  - **A:** We start with the Medicare data for a single procedure and then find that service in the Anesthesia data. There is an anesthesia time associated with that service that usually exceeds the OR skin-to-skin time (intra-service time). We then transform that time to get the OR time. We built on the work that had been done by Silber and colleagues, but also used a data source that had both the anesthesia and skin-to-skin time to calibrate how much of a reduction it would be to get to the intra-service time. Applied across all the anesthesia times available to get a number for each of the procedures.
- **Q7b:** The same RUC member responded that the RUC has always found that trying to use the anesthesia time has been problematic, so there are concerns about the validity of the way you handled the data is essential because of your reliance on intra-service time.
  - **A:** First, every model can be improved and refined. Second there was not just one single formula that was used. We saw that the data was highly correlated and were confident that it was a good source of validation.
- **Q8:** A RUC member noted that he was encouraged that the results of the models confirmed the work of the RUC. Are there plans to use this model for E/M or imaging interpretations?
  - **A:** Our project is only the surgical services, so that would be up to CMS.
- **Q9:** Can the relative value system be done with survey instruments or do we need to be measuring times?
  - **A:** We have not found a good way to measure the intensity. We recommended to survey for intra-service work, rather than the entire global period. We think that distortions have been introduced along the way by surveying for the entire global period. The survey data is empirical data for a large number of procedures it does help inform any valuation and should not be ignored.
- **Q10:** Have you looked at data from large integrated health system health medical records, which would capture more detailed data including the number of post-operative inpatient and outpatient visits?
  - **A:** The Urban Institute is working on primary data collection. Our work was focused on public data sources that were already available.
- **Q11:** Do you believe that intra-service work stays constant or not?
  - **A:** We do not know. We doubt that it is totally constant, but not sure that it is entirely offset. The mean values are built off of the current values so they

generally confirm the RUC values, but if you go beneath that you will see there are a number of redistributions across types of services.

**X. Relative Value Recommendations for CPT 2016:**

**Laryngoplasty (Tab 4)**

**Wayne Koch, MD; John T. Lanza (AAO-HNS)**

CPT code 31588 was identified via the 090-Day Global Post-Operative Visits screen. When the code family was reviewed it was determined that some codes in the family required revision to reflect the typical patient and those changes needed to be made prior to conducting a survey.

In October 2014, the CPT Editorial Panel created four new codes, revised three codes and deleted two codes to more accurately reflect the services currently performed for laryngoplasty procedures. However, following conclusion of the survey process the specialty societies realized there were multiple problems with the CPT descriptors and subsequent survey responses. In response, The American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) requested to rescind the recent CPT changes and develop a new coding structure to define laryngoplasty services for separate patient populations. AAO-HNS indicated that there are clear differences in physician time, work and post-operative care for adult versus pediatric patients. Second, AAO-HNS requested the opportunity to redefine CPT code 31580, as it describes 2-stages of services but is actually two separate procedures: one for insertion and one for removal. The pre-, intra- and post-service physician work and time are different and the patient is seen on different days for the keel insertion and for the removal. Third, the specialty asked CPT to consider deletion of CPT code 31588 since the new codes will capture this service, code 31588 may no longer be necessary. AAO-HNS intends to submit a new coding proposal for the October 2015 CPT meeting. **The specialty society requested and the RUC recommends that the laryngoplasty family of services be referred to CPT for revision. Note: On February 7, 2015, the CPT Editorial Panel rescinded all of the proposed coding changes and will consider a new proposal at the October 2015 CPT Meeting.**

**Endobronchial Ultrasound – EBUS (Tab 5)**

**Katina Nicolacakis MD (ATS), Alan Plummer, MD (ATS), Burt Lesnick (CHEST), Robert DeMarco, MD (CHEST) and Kevin Kovitz, MD (ATS and CHEST)**

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, specifically CPT 31620 *Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s)* be surveyed for physician work and develop practice expense inputs.

Subsequent to the RUC January 2014 meeting, the RUC recommended 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 typically be reported.

In October 2014, the CPT Editorial Panel deleted one code and created three new codes to describe bronchoscopic procedures that are inherently performed with Endobronchial

Ultrasound (EBUS). The following represents this newly revised family approved by the CPT editorial panel.

**31622 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic with cell washing, when performed (separate procedure)**

The RUC reviewed the survey results from 116 pulmonologists and critical care specialists and agreed that the following physician time components are appropriate for this service: pre-service time of 21 minutes, intra-service time of 30 minutes and immediate post-service time of 15 minutes.

The RUC reviewed the survey 25<sup>th</sup> percentile of 2.50 and agreed with the specialty that the current value of 2.78 is appropriate for this service. To justify this value, the RUC compared the survey code to MPC code 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU=2.82, intra-service time of 25 minutes and total time of 56 minutes) and noted that the survey code has higher intra-service time and total time, and should be valued slightly higher than the reference code. Additionally, the RUC compared the survey code to MPC code 12052 *Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU=2.87, intra-service time of 30 minutes and total time of 70 minutes) and noted that both codes have identical intra-service time, though the reference code has slightly more total time, justifying a slightly lower value for the survey code. **The RUC recommends a work RVU of 2.78 for CPT code 31622.**

**3160X1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration(s)/biopsy(ies)), one or two mediastinal and/or hilar lymph node stations or structures**

The RUC reviewed the survey results from 91 pulmonologists and critical care specialists and agreed that the following physician time components are appropriate for this service: pre-service time of 27 minutes, intra-service time of 60 minutes and immediate post-service time of 25 minutes. This newly bundled code is a procedure which bundles in the work from CPT code 31629, 31620 and 31633 (only for the 2<sup>nd</sup> lymph node station). The procedure requires two distinct bronchoscopes with one immediately following the other. First, the standard video bronchoscope is introduced into the airway and the airways are examined at the subsegmental level, then the standard bronchoscope is removed and the patient is reintubated with the endobronchial ultrasound scope. The endobronchial ultrasound scope is an angled viewing scope which is larger and more difficult to introduce and is used to image one to two lymph node stations.

The RUC observed that current coding structure for this would involve 5.49 RVUs for one lymph node station (31629+31620) and 6.82 for two lymph node stations (31629+31620+31633+31633). The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey median work RVU of 5.00 is appropriate. To justify this value, the RUC compared the survey code to top key reference code 31660 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe* (work RVU=4.25, intra-service time of 50 minutes and total time of 105 minutes) and noted that the survey code has more intra-service time and total time and therefore should be valued higher. Additionally, the RUC compared the survey 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, intra-service time of 60 minutes and total

time of 125 minutes) and noted that both services have identical intra-service times, though the survey code has less total time, supporting a somewhat lower value for the survey code.

**The RUC recommends a work RVU of 5.00 for CPT code 3160X1.**

***3160X2 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration(s)/biopsy(ies), 3 or more mediastinal and/or hilar lymph node stations or structures***

The RUC reviewed the survey results from 91 pulmonologists and critical care specialists and agreed that the following physician time components are appropriate for this service: pre-service time of 27 minutes, intra-service time of 75 minutes and immediate post-service time of 25 minutes. This newly bundled code is a procedure which bundles in the work from CPT code 31629, 31620 and 31633 (only additional lymph node stations). The procedure requires two distinct bronchoscopes with one immediately following the other. First, the standard video bronchoscope is introduced into the airway and the airways are examined at the subsegmental level, then the standard bronchoscope is removed and the patient is reintubated with the endobronchial ultrasound scope. The endobronchial ultrasound scope is an angled viewing scope which is larger and more difficult to introduce and is used to image three or more lymph node stations.

The RUC observed that current coding structure for this would involve 8.14 RVUs for three lymph node stations (31629+31620+31633+31633). The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey median work RVU of 5.50 is appropriate. To justify this value, the RUC compared the survey 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, intra-service time of 60 minutes and total time of 125 minutes) and noted that the survey code has more intra-service time though somewhat less intensity, supporting a similar valuations. Additionally, the RUC compared the survey code to CPT code 33946 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous* (work RVU= 6.00, intra-service time of 73 minutes and total time of 133 minutes, and noted that the survey code has slightly more intra-service time, though slightly less total time and a somewhat lower intensity, supporting a somewhat lower valuation. **The RUC recommends a work RVU of 5.50 for CPT code 3160X2.**

***31625 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites***

The RUC reviewed the survey results from 100 pulmonologists and critical care specialists and agreed that the following physician time components are appropriate for this service: pre-service time of 23 minutes, intra-service time of 35 minutes and immediate post-service time of 15 minutes. Although the RUC rarely approves a 75<sup>th</sup> percentile intra-service time, the RUC agreed that 35 minutes are justified, as the work of 31625 involves all of the intra-service work of 31622 (30 minutes intra-service time) and also some additional time for performance of the biopsy. The RUC also noted that of survey respondents that surveyed both 31622 and 31625, the respondents indicated that 31625 takes more time to perform.

The RUC reviewed the survey median of 3.48 RVUs and agreed with the specialty that the current value of 3.36 is appropriate for this service. To justify this value, the RUC compared the survey 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, intra-service time of 30 minutes and total time of 79

minutes) and noted that the survey code has somewhat more intra-service time though less total time, supporting a similar valuation. In addition, the RUC compared the survey code to MPC code 12052 *Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU=2.87, intra-service time of 30 minutes and total time of 70 minutes) and noted that the survey code has more intra-service time, though the survey code has similar total time relative to the reference code, justifying a higher value for the survey code. **The RUC recommends a work RVU of 3.36 for CPT code 31625.**

**31626 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple**

The RUC reviewed the survey results from 64 pulmonologists and critical care specialists and agreed that the following physician time components are appropriate for this service: pre-service time of 23 minutes, intra-service time of 45 minutes and immediate post-service time of 20 minutes.

The RUC reviewed the survey median of 4.38 RVUs and agreed with the specialty that the current value of 4.16 is appropriate for this service. To justify this value, the RUC compared the survey code to MPC code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10, intra-service time of 45 minutes and total time of 116 minutes) and noted that both services have identical intra-service times though the survey code has a higher intensity, justifying a somewhat higher value for the survey code. In addition, the RUC compared the survey code to CPT code 33992 *Removal of percutaneous ventricular assist device at separate and distinct session from insertion* (work RVU= 4.00, intra-service time of 45 minutes and total time of 105 minutes) and noted that both codes have identical intra-service times, whereas the survey code has somewhat more intensity, justifying a somewhat higher value for the survey code. **The RUC recommends a work RVU of 4.16 for CPT code 31626.**

**31628 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe**

The RUC reviewed the survey results from 101 pulmonologists and critical care specialists and agreed that the following physician time components are appropriate for this service: pre-service time of 23 minutes, intra-service time of 40 minutes and immediate post-service time of 20 minutes.

The RUC reviewed the survey median of 3.85 RVUs and agreed with the specialty that the current value of 3.80 is appropriate for this service. To justify this value, the RUC compared the survey code to MPC code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10, intra-service time of 45 minutes and total time of 116 minutes) and noted that the survey code has somewhat less intra-service time and less total time, justifying a lower value for the survey code. In addition, the RUC compared the survey code to CPT code 33992 *Removal of percutaneous ventricular assist device at separate and distinct session from insertion* (work RVU= 4.00, intra-service time of 45 minutes and total time of 105 minutes) and noted that the survey code has somewhat less intra-service time and less total time, justifying a somewhat lower value for the survey code. **The RUC recommends a work RVU of 3.80 for CPT code 31628.**

**31629 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)**

The RUC reviewed the survey results from 105 pulmonologists and critical care specialists and agreed that the following physician time components are appropriate for this service: pre-service time of 23 minutes, intra-service time of 35 minutes and immediate post-service time of 20 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey median work RVU of 4.00 is appropriate. To justify this value, the RUC compared the survey 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, intra-service time of 30 minutes and total time of 79 minutes) and noted that the survey code has more intra-service time and near identical total time, supporting a higher valuation for the survey code. In addition, the RUC compared the survey code to CPT code 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)* and noted that the survey code has more intra-service time and less total time, supporting a similar value for the survey code. **The RUC recommends a work RVU of 4.00 for CPT code 31629.**

**3160X3 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])**

The RUC reviewed the survey results from 70 pulmonologists and critical care specialists and agreed that the following physician time components are appropriate for this service: intra-service time of 30 minutes. This new add-on code is a procedure where a standard bronchoscopy is performed and then through the standard bronchoscope a catheter ultrasound probe is introduced and fed to the periphery of the lung to identify peripheral lesions for sampling and diagnosis.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25<sup>th</sup> percentile work RVU of 1.70 is appropriate. To justify this value, the RUC compared the survey code to top key reference code 31637 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented (List separately in addition to code for primary procedure)* (work RVU= 1.58, intra-service time of 30 minutes) and noted that both codes have identical intra-service time, whereas the survey code is somewhat more intense, justifying a somewhat higher work value for the survey code. In addition, the RUC compared the survey code to the second highest key reference and MPC code 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, intra-service time of 30 minutes), and noted that although both services have identical intra-service time, the reference code has a higher intensity, justifying a lower value for the survey code. **The RUC recommends a work RVU of 1.70 for CPT code 3160X3.**



***31632 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 95 pulmonologists and critical care specialists and agreed that the following physician time component is appropriate for this service: intra-service time of 18 minutes.

The RUC reviewed the survey 25<sup>th</sup> percentile RVU of 1.34 and agreed with the specialty that the current value of 1.03 is appropriate for this service. To justify this value, the RUC compared the survey code to MPC code 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.20, intra-service time of 15 minutes) and noted that although the survey code has somewhat more intra-service time than the reference code, it also has somewhat less intensity, justifying a somewhat lower work value for the survey code. In addition, the RUC compared the survey code to CPT code 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)* (work RVU= 1.16, intra-service time of 15 minutes) and noted that although the survey code has somewhat more intra-service time than the reference code, it also has somewhat less intensity, justifying a somewhat lower work value for the survey code. **The RUC recommends a work RVU of 1.03 for CPT code 31632.**

***31633 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 86 pulmonologists and critical care specialists and agreed that the following physician time component is appropriate for this service: intra-service time of 20 minutes.

The RUC reviewed the survey 25<sup>th</sup> percentile RVU of 1.50 and agreed with the specialty that the current value of 1.32 is appropriate for this service. To justify this value, the RUC compared the survey code to MPC code 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.20, intra-service time of 15 minutes) and noted that although the survey code has more intra-service time than the reference code and similar intensity, justifying a somewhat higher work value for the survey code. In addition, the RUC compared the survey code to CPT code 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)* (work RVU= 1.16, intra-service time of 15 minutes) and noted that although the survey code has more intra-service time than the reference code and similar intensity, justifying a somewhat higher work value for the survey code. **The RUC recommends a work RVU of 1.32 for CPT code 31633.**

**New Technology**

CPT codes 3160X1, 3160X2 and 3160X3 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

### **Practice Expense**

The RUC reviewed and approved the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee. Some of the modifications include the following:

- The clinical staff type for pre-service time revised from RN/RT L047C to RN/LPN/MTA L037D (lines 12-16).
- The clinical staff time for a phone call was revised to 3 minutes for nonfacility and facility settings to meet RUC standards (line 16).
- 15 minutes of RN time (per one hour monitoring) for monitoring the patient after procedure (line 34) was determined to be monitoring the patient after moderate sedation (line 33) and the line items were changed to reflect this.
- 5 liters of gas, oxygen (SD084) per intra-service physician time is what is clinically necessary for these services, however 2 liters are already provided in the pack, moderate sedation (SA044) so the supply quantity is 3 times the assist physician time (line 31). The PE Subcommittee had a robust discussion of what equipment is needed for these procedures. The Subcommittee determined that the endoscope, ultrasound probe, balloon sheath (ES014) is not needed for any of the codes and the new equipment, endoscope, ultrasound radial probe; endoscope, ultrasound probe, drive; and endoscope, ultrasound probe, processor and keyboard, is only needed for CPT code 3160X3. For CPT codes 3160X1 and 3160X2 only, the procedure requires two distinct bronchoscopes with one immediately following the other. First, the standard video bronchoscope, fiberscope, flexible, bronchoscopy (ES017), is introduced into the airway and the airways are examined at the subsegmental level, then the standard bronchoscope is removed and the patient is reintubated with the endobronchial ultrasound scope, Flexible dual-channeled EBUS bronchoscope (EQ361). The endobronchial ultrasound scope is an angled viewing scope which is larger and more difficult to introduce and is used to image three or more lymph node stations.
- All equipment minute calculations were updated to include the appropriate line items.

### **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.

### **Transcatheter Pulmonary Valve Implantation (Tab 6)**

**Richard Wright, MD (ACC); Thad Waites, MD (ACC); Cliff Kavinsky, MD (SCAI); Hari Naidu, MD (SCAI)**

#### ***3347X1 Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed***

The RUC reviewed the survey results from 45 cardiologists and agreed that the 25<sup>th</sup> percentile work value of 25.00 accurately represents the typical physician work of this procedure. The surgery involves placement of a new pulmonary valve via catheter. The specialty elaborated that this is a low volume code that is typically performed on children with a history of congenital heart defects that have had multiple surgeries prior to this procedure. The typical patient has had a failed surgery and by the time of the procedure is decompensating and therefore very ill. The typical patient is referred for surgery from another institution. The specialty also noted that although this is considered a minimally invasive procedure, the surgery and the typical patient are quite complex. Finally, the specialties noted that although this procedure was originally a 090-day procedure it was surveyed as a 000-day global in recognition of the CMS surgical global transition. Given the discussion surrounding the

complexity of the service, the RUC agreed that the high level of intensity is appropriate. The RUC agreed with the following physician time components: pre-service time of 63 minutes, intra-service time of 180 minutes and post-service time of 33 minutes.

To further justify a work RVU of 25.00 for 3347X1, the RUC compared the survey code to top key reference code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180 minutes), and agreed that the services represent analogous physician work, though the survey code has somewhat more total time, supporting a somewhat higher value for the survey code.. In addition, the RUC compared the survey code to CPT code 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* (work RVU=20.00, intra-service time 173 minutes) and noted that the survey code is slightly more intense and has more intra-service time and should therefore be valued somewhat higher. **The RUC recommends a work RVU of 25.00 for CPT code 3347X1.**

### **New Technology**

The RUC recommends that code 3347X1 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

### **Practice Expense**

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

- The RUC standard for 000-day and 010-day global codes is no pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that 30 minutes for facility based procedures may apply to a select number of codes. The specialty determined and the RUC agreed that CPT code 3347X1 requires extensive use of clinical staff time, similar to reference code 93581 and other congenital services.

### **Intravascular Ultrasound (Tab 7)**

**Matthew Sideman, MD, (SVS); Robert Zwolak, MD (SVS); David Han, MD, (SVS); Gary Seabrook, MD (SVS); Richard Wright, MD, (ACC); Thad Waites, MD, (ACC); Clifford Kavinsky, MD, (SCAI); Jerry Niedzwiecki, MD, (SIR); Michael Hall, MD, (SIR) and Timothy Swan, MD, (SIR)**

In the NPRM for 2015 MPFS, a stakeholder requested that CMS establish non-facility PE RVUs for CPT code 37250 and 37251. CMS is seeking comment regarding whether it is appropriate to have non-facility PE RVUs for these codes and if so what inputs should be assigned. In September 2014 the RUC recommended to refer this issue to CPT. At the October CPT meeting, CPT codes 37250 and 37251 were deleted and new bundled codes were developed to describe Intravascular Ultrasound (IVUS).

### ***3725X1 Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial non-coronary vessel (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results for 42 physicians and agreed that the 25<sup>th</sup> percentile work value of 1.80 accurately represents the typical physician work of this procedure. This is a newly bundled procedure which now includes radiological supervision and interpretation. In response to issues raised about whether or not pre- and post-service time would represent

duplicative work with the primary procedure code this add-on will be billed with, the pre- and post-service times were reduced to 1 minute, respectively. The RUC reviewed the survey times and agreed that the median intra-service time of 20 minutes is appropriate. The specialty reported that during the 1 minutes of pre-service time, the physician assesses the approach to the procedure, ensures appropriate equipment is available and often discusses with the patient what will be happening during the procedure. The specialty noted that although the recently valued lower extremity codes are ZZZ codes, they also were valued with 1 minute of pre-service time. Those services include codes 37222, 37223 and 27234. Code 372X1 also has inherent moderate sedation and would be reported with other codes that have inherent moderate sedation.

To further justify a work RVU of 1.80 for 3725X1, the RUC reviewed CPT code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU= 1.80, intra-service time of 25 minutes), and agreed that although the survey code has somewhat less intra-service time, it is also more intense service, warranting a similar work value. In addition, the RUC compared the survey code to CPT code 36227 *Tissue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service time of 15 minutes) and noted that even though the survey code has more intra-service time, it is a less intense procedure, warranting a somewhat lower work value for the survey code. **The RUC recommends a work RVU of 1.80 for CPT code 3725X1.**

***3725X2 Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results for 41 physicians and agreed that the 25<sup>th</sup> percentile work value of 1.44 accurately represents the typical physician work of this procedure. The RUC also agreed with the following physician time components: pre-service time of 0 minutes, intra-service time of 20 minutes and post-service time of 1 minute. The RUC confirmed that the additional minute of post-service time is not duplicative as the previously obtained images are re-reviewed for accuracy and dictated into the final operative report. The results are then discussed with the patient and family as well as the referring physician. This post-service work is necessary for each additional vessel, just as it is for the initial vessel.

To justify a work RVU of 1.44 for 3725X2, the RUC reviewed CPT code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU= 1.80, intra-service time of 25 minutes), and agreed that since the survey code has somewhat less intra-service time and similar intensity, it should have a somewhat lower value compared to the reference code. In addition, the RUC compared the survey code to CPT code 16036 *Escharotomy; each additional incision (List separately in addition to code for primary procedure)* (work RVU= 1.50, intra-service time of 20 minutes) and noted that both services have identical intra-service time and similar intensities and therefore should be valued similarly. **The RUC recommends a work RVU of 1.44 for CPT code 3725X2.**

**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 reviewed and approved the direct practice expense inputs with the following minor modifications as approved by the Practice Expense Subcommittee:

- The clinical staff time was changed from 1 to 0 for 372X2 because CPT code 372X2 is for each additional non-coronary vessel, so no clinical staff time to prepare the room, equipment and supplies is needed and is only in the initial CPT code, 372X1 (line 30)
- All equipment minute calculations were updated to include the appropriate line items.
- CMS noted that the invoice for supply item IVUS Catheter Sterile Cover (NEW) simply says box without the number included in the box. CMS requests that the specialties submit invoices that clearly detail the amount paid for the quantity listed on the PE spreadsheet without notations from the specialty. The specialty is recommending one sterile cover and listed a unit of 0.1 of the box. The specialty clarified that there are 10 sterile covers in the box.

**Mediastinoscopy with Biopsy (Tab 8)**

**Francis Nichols, MD, (STS); Stephen Lahey, MD, (STS)**

In January 2014, the RUC identified CPT code 39400 through the Pre-Time Analysis screen: services reviewed prior to April 2008 with pre-time greater than pre-time package 4 Facility - Difficult Patient/Difficult Procedure (63 minutes) Medicare Utilization over 10,000. In April 2014, the RUC reviewed the action plan for this service and referred this issue to CPT for revision.

In October 2014, the CPT Editorial Panel deleted CPT code 39400 *Mediastinoscopy, includes biopsy(ies), when performed* and created two new codes to better describe the disparate procedures and patient populations that currently receive mediastinoscopy services.

***3940X1 Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed***

The RUC reviewed the survey results for 77 thoracic surgeons and determined that the survey respondents overestimated the work RVUs. Therefore, the specialty societies recommended and the RUC agreed to crosswalk 3940X1 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 45 minutes intra-service time), which requires the same physician work and time. The RUC recommends 48 minutes pre-service time, 45 minutes intra-service time and 30 minutes immediate post-service time.

Additionally, the RUC recommends a half-day discharge day management visit 99238, which is necessary because the patient must be assessed for hemodynamic and respiratory stability (absence of occult mediastinal bleeding, no pneumothorax on exam and chest x-ray) immediately prior to discharge. Also, the discharge includes extensive discussion of the potential diagnoses established by the procedure with the patient and family, which would include benign, infectious or malignancy as well as untreatable disorders.

For additional support the RUC referenced 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing,*

*permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral (work RVU = 5.35 and 45 minutes intra-service time), which requires similar physician work and time to complete. The RUC recommends a work RVU of 5.44 for CPT code 3940X1.*

**3940X2 Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)**

The specialty societies indicated that CPT code 3940X2 replaces deleted code 39400 (010-day global, work RVU = 8.05). The specialty societies indicated that it is typical that patients receiving this 000-day service will also receive a 99213 office visit. If a 99213 (work RVU = 0.97) is typically reported with 3940X2, the recommended work RVU would be  $7.50 + 0.97 = 8.47$ , which is more than the current value of 39400 and how this service is currently reported. Therefore, the specialty society presented compelling evidence and the RUC agreed that this service has changed as well as the site of service. Incorrect assumptions were made in the previous valuation of 39400 because the vignette was misleading. The vignette described a patient whose procedure is aimed at a single diagnosis from a mass, rather than the extensive exploration and biopsy of all accessible mediastinal lymph nodes to stage lung cancer. Mediastinoscopy performed with a diagnosis of lung cancer is a much more common situation. Additional compelling evidence was provided to indicate that the patient population has changed, becoming more difficult due to new emphasis on the value of complete staging for lung cancer and transition of the simpler patients to EBUS for mediastinal node sampling

The RUC reviewed the survey results from 77 thoracic surgeons and determined the 25<sup>th</sup> percentile work RVU of 7.50 for CPT code 3940X2 appropriately accounts for the work required to perform this service. The specialty societies noted and the RUC agreed that 3940X2 describes a much more extensive procedure with additional physician work, intensity and risk than was considered in the valuation of 39400. The RUC recommends 48 minutes pre-service, 60 minutes intra-service, 30 minutes immediate post-service time and a half-day discharge day management visit 99238. A half-day discharge day management visit is necessary because the patient must be assessed for hemodynamic and respiratory stability (absence of occult mediastinal bleeding, no pneumothorax on exam and chest x-ray) immediately prior to discharge. In addition, the discharge includes extensive discussion of the multiple potential diagnoses established by the procedure with the patient and family.

The RUC compared 3940X2 to MPC code 57288 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic* (adjusted to 000-day work RVU = 8.10) and 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU = 7.50) and determined that all three services require similar physician work and 60 minutes intra-service time to perform. A work RVU of 7.50 for CPT code 3940X2 is appropriate relative to 3940X1, which requires 15 minutes less intra-service time and physician work. **The RUC recommends a work RVU of 7.50 for CPT code 3940X2.**

**Practice Expense**

The RUC reviewed and approved the direct practice expense inputs with no modifications as submitted by the specialty society and approved by the Practice Expense Subcommittee. The RUC notes the following:

The RUC standard for 000-day and 010-day codes is no pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is

appropriate. The RUC agreed that 30 minutes for facility-based procedures may apply to a select number of codes that require extensive use of clinical staff time. This procedure is currently performed in the facility. Although it is typically performed as an outpatient procedure where the patient is discharged on the same day, as a major operative undertaking, it requires all the standard office work for scheduling that is required for any operative procedure under general anesthesia, regardless of the length of the global period. Although the services are considered 000-day global procedures, clinical staff time and effort are required to assist with the planning, scheduling and coordination of the facility as well as the education, scheduling, coordination and follow-up with the patient. The specialty determined and the RUC agreed that CPT codes 3940X1 and 3940X2 require extensive use of clinical staff time, similar to key reference code 32608.

#### **Genitourinary Catheter Procedures (Tab 9)**

**Jerry Niedzwiecki, MD, (SIR); Michael Hall, MD, (SIR); Tim Swan, MD (SIR); Zeke Silva, MD, (ACR) and Kurt Schoppe, MD (SCR)**

#### **Facilitation Committee #1**

In October 2012, the Joint CPT/RUC Workgroup on Codes Reported Together identified the following code pairs as billed together 75% or more of the time: 50392 and 74475, 50393 and 74480, 50394 and 74425, 50398 and 75984. At the October 2014 CPT meeting, the specialties submitted a Code Change Proposal to bundle codes per the workgroup's request, and also refined the descriptors for injection and aspiration procedures to better delineate surgical access requirements.

Prior to valuing these services, the specialty societies noted that for two of these new services, 5039X1 and 5039X2, there is compelling evidence that the current component codes used to report these services are potentially misvalued. The specialties brought forth the following compelling evidence arguments:

#### **Change in technique and technology**

- Virtually all the medical devices currently used in the genitourinary catheter procedures have been developed since the current codes were adopted. Advances in understanding of anatomy and avoidance of complications (especially genitourinary sepsis) have led to the development of much less aggressive and safer guidewire-based methods which involve more steps and more effort, skill and physician time such as micropuncture access with gradual stepwise transition to heavy-duty guidewires, tract dilation and placement of nephrostomy catheters over a wire and use of real-time ultrasound guidance for needle access.

#### **Change in patient population**

- The population of patients treated with the genitourinary catheter procedures currently described by the family of codes being replaced by the new family of codes has changed considerably. Previously virtually all genitourinary catheter procedures were used for basic relief of urinary obstruction either acutely or chronically, but as a result of major advances in urologic surgery, patients with malignancies, stone disease and other problems are now being managed with innovative reconstructive

techniques including the regular need for and use of catheter based procedures, including urinary drainage.

After hearing these arguments, the RUC agreed that there is compelling evidence that the current work values for 5039X1 and 5039X2 are potentially misvalued.

**5039X1 Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access**

The RUC reviewed the survey results for 45 interventional radiologists and recommends the following physician time components: pre-service time of 36 minutes, intra-service time of 35 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5039X1, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25<sup>th</sup> percentile work RVU of 3.15 is appropriate. To justify a work RVU of 3.15, the RUC compared the surveyed code to the top two key reference services chosen: CPT code 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU= 3.12, intra time= 30 minutes) and CPT code 49405 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous* (work RVU= 4.25, intra time= 40 minutes). The RUC noted that both services provide comparable physician work and the recommended work value of 3.15 appropriately places 5039X1 in rank order between these two reference services. **The RUC recommends a work RVU of 3.15 for CPT code 5039X1.**

**5039X2 Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access**

The RUC reviewed the survey results for 45 interventional radiologists and recommends the following physician time components: pre-service time of 25 minutes, intra-service time of 15 minutes and post-service time of 15 minutes.

To determine an appropriate work value for 5039X2, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25<sup>th</sup> percentile work RVU of 1.42 is appropriate. To justify a work RVU of 1.42, the RUC compared the surveyed code to the second highest chosen key reference code 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU= 2.00) and noted that the reference code has slightly more total time than 5039X2, 60 minutes compared to 55 minutes, and is valued appropriately higher. The RUC also reviewed reference code 64445 *Injection, anesthetic agent; sciatic nerve, single* (work RVU= 1.48, intra time= 15 minutes) and MPC code 52000 *Cystourethroscopy (separate procedure)* (work RVU= 2.23, intra time= 15 minutes) and noted that both services provide comparable physician work and the recommended work value of 1.42 appropriately places 5039X2 relative to these two reference services. **The RUC recommends a work RVU of 1.42 for CPT code 5039X2.**



**5039X3 Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

The RUC reviewed the survey results for 45 interventional radiologists and recommends the following physician time components: pre-service time of 39 minutes, intra-service time of 48 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5039X3, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25<sup>th</sup> percentile work RVU of 4.70 is appropriate. To justify a work RVU of 4.70, the RUC compared the surveyed code to the top two key reference services chosen: CPT code 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50, intra time= 45 minutes) and CPT code 49405 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous* (work RVU= 4.25, intra time= 40 minutes). The RUC agreed that considering the similarities in physician work and time, these two reference services are appropriately valued analogous to 5039X3.

Finally, the RUC noted that physician work involved in 5039X3 is the work involved in 5039X1 plus the work of re-accessing a system in a peripheral calyx. Therefore, the physician is accessing the system twice in 5039X3 and justifies a work RVU 1.55 difference greater than 5039X1. **The RUC recommends a work RVU of 4.70 for CPT code 5039X3.**

**5039X4 Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access**

The RUC reviewed the survey results for 46 interventional radiologists and recommends the following physician time components: pre-service time of 39 minutes, intra-service time of 60 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5039X4, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that neither the 25<sup>th</sup> percentile (work RVU= 5.00) nor the median work RVU (work RVU= 6.20) accurately values 5039X4. To determine a more accurate value, the RUC reviewed CPT code 52351 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic* (work RVU= 5.75) and noted that both codes have similar physician work and nearly identical total time. Given these similarities, the RUC recommends a work RVU of 5.75, which is a direct crosswalk to CPT code 52351. To justify this value, the RUC compared 5039X4 to CPT code 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 5.85, intra time= 60 minutes) and noted that since both codes have identical intra-service time and comparable physician work, the recommended value is appropriately valued analogous to this reference code.

Finally, the RUC noted that the work involved in 5039X4 contains the physician work of 5039X3 plus the additional work of transversing the ureter and placing the catheter into the bladder and having it then travel externally to the patient. The RUC agreed that the additional incremental work of 1.05 above the recommended value of 4.70 for CPT code 5039X3 is accurate. **The RUC recommends a work RVU of 5.75 for CPT code 5039X4.**

**5039X13 Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; via pre-existing nephrostomy tract**

The RUC reviewed the survey results for 45 interventional radiologists and recommends the following physician time components: pre-service time of 36 minutes, intra-service time of 45 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5039X13, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25<sup>th</sup> percentile work RVU of 4.20 is appropriate. To justify a work RVU of 4.20, 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 noted that since this reference code has 5 fewer minutes than the surveyed code, 40 minutes compared to 45 minutes, 5039X13 is appropriately valued higher. In addition, the RUC reviewed CPT code 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50) and agreed that with identical intra-service time, these two codes should be valued similarly.

Finally, the RUC noted that the work involved in 5039X13 contains the physician work of 5039X2 plus the additional work of traversing the ureter with a new catheter analogous to 5039X4, where this new catheter extends from the bladder, through the ureter, is coiled in the kidney, and extends external to the patient. The RUC agreed that the additional work increment between this procedure and the injection procedure is accurate. **The RUC recommends a work RVU of 4.20 for CPT code 5039X13.**

**5039X5 Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

The RUC reviewed the survey results for 44 interventional radiologists and recommends the following physician time components: pre-service time of 20 minutes, intra-service time of 20 minutes and post-service time of 15 minutes.

To determine an appropriate work value for 5039X5, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25<sup>th</sup> percentile work RVU of 2.00 is appropriate. To justify a work RVU of 2.00, the RUC compared the surveyed code to the key reference code 49452 *Replacement of gastro-jejunoscopy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 2.86, total time= 60 minutes) and noted that the reference code has slightly more total time compared to the surveyed code and is appropriately valued higher. The RUC also reviewed CPT code 47000 *Biopsy of liver, needle; percutaneous* (work RVU= 1.90, intra time= 20 minutes) and agreed that this reference code should be valued similarly to 5039X5. **The RUC recommends a work RVU of 2.00 for CPT code 5039X5.**

**5069X7 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; via a pre-existing nephrostomy tract**

The RUC reviewed the survey results for 33 interventional radiologists and recommends the following physician time components: pre-service time of 39 minutes, intra-service time of 45 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5069X7, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey median work RVU of 4.60 is appropriate. To justify a work RVU of 4.60, the RUC compared the surveyed code to CPT code 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50) and noted that both services have identical intra-service time, 45 minutes, and should therefore be valued similarly. The RUC also reviewed CPT code 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 agreed that this reference code also provides an accurate anchor point to the recommended value.

Finally, the RUC noted that 5069X7 is analogous to the physician work involved in 5039X13. However, the placement of the ureteral catheter does not have external connections to the skin surface. Therefore, during deployment of the stent, there is significant risk of stent migration and malposition. This adds additional intensity compared to 5039X13 and the recommended value appropriately values the surveyed code above this reference code. **The RUC recommends a work RVU of 4.60 for CPT code 5069X7.**

**5069X8 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter**

The RUC reviewed the survey results for 33 interventional radiologists and recommends the following physician time components: pre-service time of 39 minutes, intra-service time of 62 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5069X8, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25<sup>th</sup> percentile work RVU of 6.00 is appropriate. To justify a work RVU of 6.00, the RUC compared the surveyed code to the second highest chosen key reference code 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29) and agreed that since both services have comparable physician work and nearly identical intra-service time, 60 minutes compared to 62 minutes, both should be valued similarly. The RUC also reviewed CPT code 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 5.85, intra time= 60 minutes) and agreed that both this reference code and 5069X8 should be valued similarly.

Finally, the RUC noted that 5069X8 is analogous to the physician work involved in 5069X7 except that there is not a pre-existing nephrostomy tract. Therefore, the additional work

increment of placing the ureteral stent in a new access is accurately valued at 1.40 work RVUs. **The RUC recommends a work RVU of 6.00 for CPT code 5069X8.**

**5069X9 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter**

The RUC reviewed the survey results for 33 interventional radiologists and recommends the following physician time components: pre-service time of 39 minutes, intra-service time of 75 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5069X9, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey median work RVU of 7.55 is appropriate. To justify a work RVU of 7.55, the RUC compared the surveyed code to the key reference code 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29) and noted that the surveyed code has more intra-service time compared to the reference code, 60 minutes compared to 75 minutes, and is therefore appropriately valued higher. The RUC also reviewed CPT code 20982 *Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency* (work RVU= 7.27, intra time= 80 minutes) and agreed that this reference code is accurately valued similar to the surveyed code.

Finally, the RUC noted that the work involved in 5069X9 contains the physician work of 5069X8 plus the additional work of placing a nephrostomy tube. The RUC agreed that the additional work increment involved in the tube placement is accurately valued at 1.55 work RVUs. **The RUC recommends a work RVU of 7.55 for CPT code 5069X9.**

**CPT Referral:**

The RUC had significant concerns regarding the global period used for the following CPT codes: 506XX6, 507XX11 and 507XX12. The specialties noted that this code is almost always billed with another code. Since it was designated by CPT as -51 modifier exempt, the RUC was concerned that the pre- and post-service work would be duplicative. The specialties suggested that the surveyees had assumed that the code was a stand-alone code, and therefore assigned it pre- and post-work. The specialty societies agreed with the RUC that these three codes should be referred to the CPT Editorial Panel. Following referral, new surveys can be conducted, this time as add-on procedures, with new recommendations presented at the April 2015 meeting. **The RUC recommends CPT codes 506XX6, 507XX11 and 507XX12 be referred to the February 2015 CPT Editorial Panel. Note: The CPT Editorial Panel converted these codes to add-on codes at the February 2015 RUC Meeting.**

In addition, prior to the meeting, the specialties indicated that CPT code 50395 *Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous*, which was identified as part of the family, will be referred to the CPT Editorial Panel to clear up any confusion with overlap in physician work with 5039X3. **The RUC recommends CPT code 50395 be referred to the CPT Editorial Panel.**

**Not Part of Family:**

The specialties noted that two CPT codes identified as part of the family, 50391 and 50396, are current stand-alone procedure that do not describe introduction/exchange/removal of catheters within the renal pelvis and should not be considered part of the family of codes under this tab. The RUC agreed that these two codes were not part of the current family under review.

**New Technology:**

The RUC recommends that this family of codes be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

**Practice Expense:**

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

- The clinical staff time for availability of prior images confirmed, was changed from 3 to 2 minutes for nonfacility setting to meet baseline standards for digital imaging (line 22).
- The clinical staff time for patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocol by radiologist, was changed from 0 to 2 minutes for nonfacility setting to meet baseline standards for digital imaging (line 23).
- The clinical staff time for obtain vital signs, was changed from 2 to 5 minutes for a standard level 2 (4-6 vitals) (line 29).
- The specialty had recommended 60 minutes (15 minutes of RN time per hour of monitoring) representing 4 hours of monitoring the patient after moderate sedation, however the PE Subcommittee determined that 15 minutes representing 1 hour of monitoring the patient after moderate sedation (line 43) was appropriate and moved the remaining 45 minutes of monitoring time to the appropriate line for monitoring the patient after procedure, not related to moderate sedation (line 44). The clinical staff type for monitoring the patient after procedure, not related to moderate sedation was changed from RN/LPN/MTA L037D to an RN L051A because that is the staff available in the office for these types of procedures (line 44).
- The clinical staff time for review examination with interpreting MD, was changed from 0 to 2 minutes for nonfacility setting to meet baseline standards for digital imaging (line 53).
- The clinical staff time for exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue, was changed from 0 to 1 minute for nonfacility setting to meet baseline standards for digital imaging (line 54).
- The PE Subcommittee had a robust discussion about use of the angiography room for these services. Unfortunately, in error, the equipment list for the angiography room has not been included in the PE reference materials for a number of years. AMA staff tracked down a list from 2003 and the equipment appears to remain unrevised since that time. The specialty advisors reviewed the equipment list in detail and verified that the angiography room, and not a subset of mobile equipment, is needed for these services.
- The equipment minute calculations were updated to include the appropriate line

**Penile Trauma Repair (Tab 10)**

**Thomas Turk, MD (AUA) and Martin Dineen, MD (AUA)**

**Facilitation Committee# 2**

At the October 2014 CPT Editorial Panel Meeting, two codes were established to report the repair of a traumatic corporeal tear of the penis and complete re-implantation of the penis.

**5443X1 Repair of traumatic corporeal tear(s)**

The RUC reviewed the survey results from 35 urologists and agreed on the following physician time components: Pre-service time package 3 (facility, straightforward patient, difficult procedure) with the standard total pre-service time of 51 minutes, intra-service time of 60 minutes and immediate post-service time of 30 minutes. The RUC noted that while the survey respondents indicated that a hospital visit is typical, the additional site-of-service data did not corroborate this assumption, since only 44% of the respondents who see the patient overnight perform an Evaluation and Management service on the same day. Therefore, no hospital visit is typical in the post-operative period for 5443X1. The RUC also discussed whether or not all four of the office visits met the threshold for a 99213. The specialty agreed that since the fourth visit is simply assessing the penial rehabilitation response from a previous visit, it only met the requirements of a 99212. The RUC recommends the following post-operative visits: one full-day discharge management (99238), one 99212 and three 99213 office Evaluation and Management services.

The RUC then reviewed the survey respondents' estimated physician work values and agreed with the specialty society that the 25<sup>th</sup> percentile work RVU of 11.50 accurately values this procedure. To justify a work RVU of 11.50, the RUC compared the surveyed code to the key reference service 54406 *Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis* (work RVU= 12.89) and agreed that the recommended value of 11.50 for 5443X1 is appropriately valued lower than this reference service due to less total time, 264 minutes compared to 295 minutes. The RUC also reviewed CPT code 67039 *Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation* (work RVU= 13.20) and noted that while both services have identical intra-service time, 60 minutes, the reference code is a more intense procedure. Therefore, the RUC recommended value for the surveyed code is appropriately valued slightly less than this reference code. **The RUC recommends a work RVU of 11.50 for CPT code 5443X1.**

**5443X2 Replantation, penis, complete amputation including urethral repair**

The RUC reviewed the survey results and agreed on the following physician time components: Pre-service time package 4 (facility, difficult patient, difficult procedure) with the standard total pre-service time of 58 minutes, intra-service time of 180 minutes and immediate post-service time of 28 minutes. The RUC also reviewed the post-operative visits and agreed that the following number of post-operative visits was necessary due to the extremely high level of complexity of the patient who is typically schizophrenic and the time intensive nature of the continuous follow-up care: two 99232 and one 99233 hospital visits, one full-day 99238 discharge management code and four 99213 office visits.

The RUC then reviewed the survey respondents' estimated physician work values and agreed with the specialty society that the median work RVU of 24.50 accurately valued this procedure. To justify a work RVU of 24.50, the RUC compared the surveyed code to the key reference service 53448 *Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative*

*session including irrigation and debridement of infected tissue* (work RVU= 23.44) and agreed that since 5443X2 has slightly more intra-service time compared to the reference code, 180 minutes and 170 minutes, respectively, the median value of 24.50 accurately values the surveyed code higher. In addition, the RUC reviewed 23473 *Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component* (work RVU= 25.00) and noted that both services have identical intra-service time, 180 minutes, and should be valued similarly. **The RUC recommends a work RVU of 24.50 for CPT code 5443X2.**

**Emergent Procedure:**

There was discussion at the table concerning potential overlap between an E/M service billed on the same date due to the emergent nature of this procedure. It was noted that the Practice Expense Subcommittee, the previous day, discussed the necessary pre-service clinical labor during this tab and realized that the Subcommittee and the RUC have previously accepted varying time elements for emergent procedures. Therefore, it was decided that AMA staff will go back and perform an exhaustive search of emergent procedure previously valued by the RUC to determine precedence for establishing pre time both in clinical labor and physician work.

**Practice Expense:**

The RUC reviewed and approved the direct practice expense inputs with no modifications as submitted by the specialty society and approved by the Practice Expense Subcommittee. The RUC notes the following:

- The PE Subcommittee considered reducing the pre-service time from 60 minutes to 15 minutes based on a direct crosswalk to CPT code 44950 *Appendectomy*, which is clearly an emergent service based on the description of the typical patient in the vignette. The PE Subcommittee noted that CPT code 44960 *Appendectomy; for ruptured appendix with abscess or generalized peritonitis* also has 15 minutes of pre-service time. The PE Subcommittee discussed that there was precedence for reducing the amount of pre-service time from the 60 minutes that is standard for most 90 day global services for emergency surgery. The Chair and AMA staff examined a number of services that were cited as being emergent and it was not clear that the PE Subcommittee has been consistent in reducing pre-service time in these instances and the code descriptors and vignettes did not identify the services as definitively emergent. The PE Subcommittee decided to approve the specialty society's recommendation for 60 minutes of pre-service time in the facility setting for both services to be consistent with past recommendations, however the RUC will research emergent codes and consider implementing revised pre-service time for these services.

**Intrastomal Corneal Ring Implantation (Tab 11)**

**David Glasser, MD, (AAO) and Stephen A. Kamenetzky, MD (AAO)**

**Facilitation Committee #3**

At the October 2014 CPT Editorial Panel meeting, the Panel created one new CPT Category I code to describe implantation of intrastomal corneal ring segments.

***657XX7 Implantation of intrastomal corneal ring segments***

The RUC reviewed the survey results from 34 ophthalmologists and agreed with the specialty on the following physician time components: pre-service time of 23 minutes (standard pre-

time package 6A), an intra-service time of 30 minutes and an immediate post-service time of 10 minutes (standard post-time package 7A minus 8 minutes to match the survey results). The RUC also agreed with the specialty that the following office visits during the 90-day global period were justified: one 99212 office visit 1 day after the procedure to confirm alignment of the corneal ring, one 99212 office visit 1-2 weeks post-op to examine healing, potential inflammation and that the corneal ring is still in place, one 99213 office visit to remove the sutures, and one 99212 office visit 3 months out to confirm the results of the procedure.

The RUC reviewed the survey respondents' estimated physician work values and agreed that they were overvalued, with a 25<sup>th</sup> percentile work RVU of 9.75. To determine an appropriate work value, the RUC compared the survey code to CPT code 67917 *Repair of ectropion; extensive (eg, tarsal strip operations)* (work RVU=5.93, intra-time of 33 minutes, total time of 142 minutes) and noted that both codes have similar intra-service times, total times and intensities, they should be valued similarly. Therefore, the RUC recommends a direct work RVU crosswalk from code 67917 to code 657XX7. To further support this recommendation, the RUC examined CPT Code 67916 *Repair of ectropion; excision tarsal wedge* (work RVU=5.48, intra-time of 25 minutes, total time of 134 minutes) and CPT Code 25605 *Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation* (work RVU=6.25, intra-time of 30 minutes, total time of 169 minutes), and agreed that the survey code recommendation is appropriately bracketed by these two reference services. **The RUC recommends a work RVU of 5.93 for CPT Code 657XX7.**

### **New Technology**

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

### **Practice Expense**

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

- The specialty had recommended 2 minutes to prepare room, equipment, and supplies (line 24) and 5 minutes to setup scope (line 25). The PE Subcommittee questioned this because no scope is listed and the specialty explained that the femtosecond laser is generally attached to the microscope, operating (EQ183) and this equipment requires the same amount of time to set up as a scope. The RUC agreed that more time than the standard 2 minutes is need to set up the equipment, however to avoid confusion they removed the 5 minutes of clinical staff time standard to setup a scope in line 25 and added it to the time in line 24 for a total of 7 minutes for prepare room, equipment, supplies (line 24) and 0 minutes for setup scope (line 25).
- The clinical staff time for Clean Surgical Instrument Package, was changed from 10 to 15 minutes to reflect the standard for cleaning a medium surgical instrument package (line 37).
- The specialty explained that the femtosecond laser is new technology and is generally attached to a microscope that the practice already owns so the microscope, operating (EQ183), was added to the equipment (line 83).
- All equipment minute calculations were updated to include the appropriate line items.



**Scleral Buckling Retinal Detachment Repair (Tab 12)**

**Michael X. Repka, M.D. (AAO); Stephen A. Kamenetzky, M.D. (AAO); John T. Lanza, M.D. (AAO – HNS)**

In January 2014, the RUC reviewed 090-day global services (based on 2012 Medicare utilization data) and identified 10 services, reported at least 1,000 times per year that included more than 6 office visits. The RUC requested these services be surveyed for work and review the practice expense for the January 2015 RUC meeting. CPT code 67113 was identified in this screen and the AAO indicated that 67108 was a related service along with 67112. In October 2014, the CPT Editorial Panel deleted 67112 and revised five codes. Although, the revisions to these codes were considered editorial, they, along with 67110 were added as part of the family of services to be reviewed at the January 2015 RUC meeting.

The specialty explained that they did not submit survey data for CPT codes 67101, 67105, 67107, 67108, 67110 and 67113 at the January 2015 RUC meeting. For 67108 and 67113, it was due to concern over the CMS final decision to transition all surgical codes with 010- and 090-day global period to 000-day globals. Specifically, the specialty was worried that CMS, as they did to several codes in the 2015 Final Rule, would choose to use the reverse building block methodology to value the 090-day globals as a 000-day globals. The RUC noted that CMS has been clear that they will still accept RUC recommendations for surgical global codes which cannot adequately be surveyed, at this time, as 000-day globals. For 67101, 67105, 67107 and 67110, the specialty indicated that they did not submit survey data for these services as the CPT changes to these services were editorial and they did not believe that these codes were part of the same family as CPT codes 67108 and 67113. The RUC had a robust discussion regarding these services, and determined that CPT codes 67101, 67105, 67107, 67108, 67110 and 67113 should all be surveyed as a family for the April 2015 RUC meeting. The RUC reiterated its clear position that given that CPT code 67101, 67105, 67107, 67108, 67110 and 67113 were identified through the RAW process under the 090-day global post-operative visit screen (either directly or indirectly as being part of the same family), the current potentially misvalued code project cannot stop as a long-term strategy is formed to address the surgical global transition. **Therefore, the RUC recommends that survey data be presented for CPT codes (67101, 67105, 67107, 67108, 67110 and 67113) at the April 2015 RUC Meeting.**

**Cerumen Removal – PE Only (Tab 13)**

**Jennifer Aloff, MD (AAFP); Steve Krug, (AAP)**

At the October 2014 CPT Editorial Panel Meeting a new code was established for removal of impacted cerumen using irrigation lavage. The PE Subcommittee reviewed this issue which is performed by a RN/LPN/MTA L037D in the nonfacility setting. This service is typically performed on the same day as an evaluation and management service. The PE Subcommittee had a robust discussion of potential duplication between the E/M and this service, but ultimately determined that the pre-service and post-service portions of the service period are not duplicative of the work that is done during the E/M service. The Subcommittee was particularly concerned that separate cleaning time was needed for this service and determined that the time was warranted given that water is being used and the procedure is typically messy, which is compounded by the fact that it is typically performed on a child, whom may have a hard time sitting still. The RUC reviewed and approved the direct practice expense inputs with the following minor modifications as approved by the Practice Expense Subcommittee:

- The pack, minimum multi-specialty visit (SA048) was removed because it is duplicative of the E/M service
- All equipment minute calculations were updated to include the appropriate line items.

**Radiologic Exam - Spinal Curvature and Instability (Tab 14)**

**Zeke Silva, MD (ACR); Kurt Schoppe, MD, (ACR); Daniel Wessell, MD, (ACC); Greg Nicola, MD, (ASNR); Josh Hirsch, MD, (ASNR); William Creevy, MD, (AAOS); John Heiner, MD (AAOS)**

In October 2014, the CPT Editorial Panel deleted three codes, revised one code and created four new codes to standardize the hierarchy and nomenclature for this code family.

**7208X1 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view**

The RUC reviewed the survey results from 50 radiologists, neuroradiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 5 minutes, and immediate post-service time of 1 minute.

The RUC reviewed the respondents' estimated median work RVU of 0.30 and agreed with the specialties that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.30, the RUC reviewed the top two key reference services: CPT code 74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views* (work RVU= 0.27, total time= 5 minutes) and CPT code 72110 *Radiologic examination, spine, lumbosacral; minimum of 4 views* (work RVU= 0.31, total time= 8 minutes. The RUC agreed that the surveyed code, with 7 minutes of total time and a work RVU of 0.30, is accurately bracketed between the two services. In addition, the RUC compared 7208X1 to MPC code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32, total time= 8 minutes) and agreed that the recommended work value and physician times accurately value the surveyed code slightly less than this reference code. **The RUC recommends a work RVU of 0.30 for CPT code 7208X1.**

**7208X2 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 2 or 3 views**

The RUC reviewed the survey results from 50 radiologists, neuroradiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 6 minutes, and immediate post-service time of 1 minute.

The RUC reviewed the respondents' estimated median work RVU of 0.35 and agreed with the specialties that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.35, the RUC reviewed the top two key reference services: CPT code 72110 *Radiologic examination, spine, lumbosacral; minimum of 4 views* (work RVU= 0.31, total time= 8 minutes and MPC code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32, total time= 8 minutes). The RUC agreed that the surveyed code should be valued slightly higher than both these reference services because 7208X2 has higher intra-service time compared to the reference services (6 minutes compared to 5 minutes). The RUC also compared 7208X2 to the family code 7208X1 and agreed that the 2 or 3 view x-ray should be valued higher than the single view. **The RUC recommends a work RVU of 0.35 for CPT code 7208X2.**

**7208X3 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 4 or 5 views**

The RUC reviewed the survey results from 50 radiologists, neuroradiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 7 minutes, and immediate post-service time of 1 minute.

The RUC reviewed the respondents' estimated median work RVU of 0.39 and agreed with the specialties that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.39, the RUC reviewed the top two key reference services: MPC code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32, total time= 8 minutes) and 72052 *Radiologic examination, spine, cervical; 6 or more views* (work RVU= 0.36, total time= 8 minutes). The RUC agreed that the surveyed code should be valued slightly higher than both these reference services because 7208X3 has higher intra-service time compared to the reference codes (7 minutes compared to 5 minutes). To further justify this value, the RUC compared 7208X3 4 or 5 views to the family code 7208X2 2 or 3 views and agreed that 7208X3 is appropriately valued slightly higher, due to greater total time of 9 minutes compared to 8 minutes. **The RUC recommends a work RVU of 0.39 for CPT code 7208X3.**

**7208X4 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); minimum of 6 views**

The RUC reviewed the survey results from 50 radiologists, neuroradiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 8 minutes, and immediate post-service time of 1 minute.

The RUC reviewed the respondents' estimated median work RVU of 0.45 and agreed with the specialties that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.45, the RUC reviewed the top two key reference services: MPC code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32, total time= 8 minutes) and 72052 *Radiologic examination, spine, cervical; 6 or more views* (work RVU= 0.36, total time= 8 minutes). The RUC agreed that the surveyed code should be valued slightly higher than both these reference services because 7208X4 has higher intra-service time compared to the reference codes (8 minutes compared to 5 minutes). To further justify this value, the RUC compared 7208X4 to the rest of the surveyed spine x-ray family of services and agreed that this service should be valued the highest due to having the greatest amount of physician work and total time (10 minutes). **The RUC recommends a work RVU of 0.45 for CPT code 7208X4.**

**RUC Review of Family Services:**

The RUC noted that several additional spine codes were added as part of the initial review of this tab. However the RUC agreed with the specialty society that the following services (72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114 and 72120) were not part of the family of spinal curvature and instability services as described by 7208X1-X4. Spinal curvature and instability is a different family than the other spine plain film codes. Spinal curvature and instability radiography (multi-segment spine radiography) differs from the standard radiograph of a single region of the spine (e.g. lumbar spine radiography) in that, while both techniques allow for evaluation of local or regional pathology of the spine, spinal curvature and instability radiography of the entire spine is required to evaluate more extensive pathology involving multiple levels of the spine or even the entire spine and body. Furthermore, evolution to digital imaging also supports the important differences between the spinal curvature and instability family and the other spine

codes. In the past, the coverage of this type of imaging was limited to the region of the body that would fit onto a long film cassette. However, with the advancement of new digital imaging techniques, the region of coverage is no longer limited as the various acquisitions can be digitally “pasted” into a single image for interpretation.

**Practice Expense:**

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

- The specialty did not have the pre-service digital inputs listed, so in order to be consistent with the codes included in the transition from film to digital imaging, the clinical staff time for availability of prior images confirmed, was added and assigned 2 minutes to meet baseline standards for digital imaging (line 17).
- The specialty did not have the pre-service digital inputs listed, so in order to be consistent with the codes included in the transition from film to digital imaging, the clinical staff time for patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocolled by radiologist, was added and assigned 2 minutes to meet baseline standards for digital imaging (line 18).

**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.

**Radiologic Exam – Hip and Pelvis (Tab 15)**

**Ezequiel Silva III, MD (ACR); William Creevy, MD (AAOS)**

In 2011, the RUC identified CPT code 73500 as being billed with 72170 greater than 75% of the time together on the same date of service. Due to the large volume of work given to the interested specialty societies, creation of a bundled code solution was not expected prior to the CPT 2016 CPT cycle. Therefore, in October 2014, the CPT Editorial Panel deleted 6 codes and created 8 codes to report bundled hip and pelvis radiologic exams.

The specialty societies noted that following their survey process for the new eight codes in this tab at the January 2015 RUC meeting, at least one of the codes did not meet the required respondent threshold based on an estimated utilization over one million times annually in the Medicare population. The specialties noted that for most of the codes in the family they did receive a sufficient number of surveys, but delayed presentation of the entire tab to ensure relativity comparisons within the family. The RUC discussed whether the current number of surveys would suffice or whether additional surveys should be acquired to reach the required thresholds for all codes in the family. **The RUC agreed that the specialty society should present to the Research Subcommittee the estimated Medicare utilization for each of the new services and determine the proper means for acquiring additional survey data. The RUC will consider the survey data at the April 2015 RUC meeting.**

**Surface Radionuclide High Dose Radiation Brachytherapy (Tab 16)**

**Michael Kuettel, MD (ASTRO); James Goodwin, (ASTRO); Sheila Rege, (ACRO)**

In October 2014, the CPT Editorial Panel created five new codes, deleted three codes and revised one code to report High Dose Rate (HDR) surface brachytherapy treatments for skin cancer.

***7778X1 Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel***

The RUC reviewed the survey results from 61 radiation oncologists and agreed on the following physician time components: pre-service time of 4 minutes, intra-service time of 25 minutes and post-time of 3 minutes. The RUC noted that a single unit of basic dosimetry (77300) is bundled into the newly created survey code and constitutes 15 minutes of the intra-service time for 7778X1. The specialty explained that the dosimetry calculation is done prior to the patient's arrival and is done on the day of the treatment. 7778X1 is typically performed twice per week for 3 weeks. There are federal, state and Nuclear Regulatory Commission (NRC) requirements which only permit a radiation oncologist, as authorized user, to perform HDR treatment and require the radiation oncologist to be present at the HDR console during the entire treatment.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 7778X1 and agreed with the specialty that the survey 25<sup>th</sup> percentile work RVU of 1.05 is appropriate for this service. The RUC compared the survey code to CPT code 74280 *Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon* (work RVU= 0.99, intra-service time of 20 minutes, total time of 32 minutes) and noted that both services have identical total time, though the survey code has more intra-service time and is therefore appropriately valued somewhat higher than the reference code. Additionally, the RUC compared the survey code to CPT code 93295 *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional* (work RVU= 1.29, intra-service time of 22.5 minutes and total time of 37.5 minutes) and noted that with similar intra-service times (25 minutes vs. 22.5 minutes) and less total time, the survey code is appropriately valued somewhat less than the reference code. **The RUC recommends a work RVU of 1.05 for CPT code 7778X1.**

***7778X2 Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions***

The RUC reviewed the survey results from 61 radiation oncologists and agreed on the following physician time components: pre-service time of 4 minutes, intra-service time of 35 minutes and post-time of 3 minutes. The RUC noted that a single unit of basic dosimetry (77300) is bundled into the newly created survey code and constitutes 15 minutes of the intra-service time for 7778X1. The specialty explained that the dosimetry calculation is done prior to the patient's arrival and is done on the day of the treatment. The RUC noted that 7778X2 has more time than 7778X1 primarily due to 7778X2 having more time during delivery of multiple channels instead of one and for connecting the applicators and tubes. 7778X2 is typically performed twice per week for 3 weeks. There are federal, state and Nuclear Regulatory Commission (NRC) requirements which only permit a radiation oncologist, as authorized user, to perform HDR treatment and require the radiation oncologist to be present at the HDR console during the entire treatment.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 7778X2 and agreed with the specialty that the survey 25<sup>th</sup> percentile work RVU of 1.40 is appropriate for this service. The RUC compared the survey code to the second highest key reference code 77306 *Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)* and noted that both codes

have similar intra-service times and total times and should therefore be valued similarly. The RUC also compared the survey code to MPC code 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU=1.54, intra-service time= 29 minutes, total time= 49 minutes) and noted that the survey code has more intra-service time, though slightly less intensity and is therefore appropriately valued somewhat lower than the reference code. **The RUC recommends a work RVU of 1.40 for CPT code 7778X2.**

***7778X3 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel***

The RUC reviewed the survey results from 64 radiation oncologists and agreed on the following physician time components: pre-service time of 6 minutes, intra-service time of 45 minutes and post-time of 10 minutes. The RUC noted that a single unit of basic dosimetry (77300) is bundled into the newly created survey code and constitutes 15 minutes of the intra-service time for 7778X1. The specialty explained that the dosimetry calculation is done prior to the patient's arrival and is done on the day of the treatment. The RUC noted that 7778X3 has more post-service time to account for the additional time needed to discuss physical/sexual activity and symptom management and instruct the patient on usage of the vaginal dilator. There are typically performed weekly for a total of two treatments. There are federal, state and Nuclear Regulatory Commission (NRC) requirements which only permit a radiation oncologist, as authorized user, to perform HDR treatment and require the radiation oncologist to be present at the HDR console during the entire treatment.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 7778X3 and agreed with the specialty that the survey 25<sup>th</sup> percentile work RVU of 1.95 is appropriate for this service. The RUC compared the survey code to CPT code 90834 *Psychotherapy, 45 minutes with patient and/or family member* (work RVU=2.00, intra-service time of 45 minutes, total time of 60 minutes) and noted that both services have identical intra-service times and similar total times and therefore should be valued similarly. Additionally, the RUC compared the survey code to CPT code 95863 *Needle electromyography; 3 extremities with or without related paraspinal areas* (work RVU= 1.87, intra-service time of 40 minutes and total time of 61 minutes) and noted that both services have identical total time, whereas the survey code has more intra-service time, supporting a slightly higher work RVU for the survey code. **The RUC recommends a work RVU of 1.95 for CPT code 7778X3.**

***7778X4 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels***

The RUC reviewed the survey results from 64 radiation oncologists and agreed on the following physician time components: pre-service time of 6 minutes, intra-service time of 70 minutes and post-time of 15 minutes. The RUC noted that a single unit of basic dosimetry (77300) is bundled into the newly created survey code and constitutes 15 minutes of the intra-service time for 7778X1. The specialty explained that the dosimetry calculation is done prior to the patient's arrival and is done on the day of the treatment. The RUC noted that 7778X4 has more intra-service time than 7778X3 primarily due to additional time need to perform the additional channels. This service is a breast brachytherapy case and includes additional post-service time to secure the catheters to the chest wall, go over the acute side-effects post-treatment as well as additional instructions for the patient. Treatment is typically given over 5 days for 7778X4 per patient. There are federal, state and Nuclear Regulatory Commission (NRC) requirements which only permit a radiation oncologist, as authorized user, to perform HDR treatment and require the radiation oncologist to be present at the HDR console during the entire treatment.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 7778X4 and agreed with the specialty that the survey 25<sup>th</sup> percentile work RVU of 3.80 is appropriate for this service. The RUC compared the survey code to CPT code 99245 *Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.* (work RVU= 3.77, intra-service time of 60 minutes and total time of 90 minutes) and noted that the survey code has 10 more minutes of intra-service time and very similar total time, and therefore should be valued similarly to the reference code. Additionally, the RUC compare the survey code to top key reference code 77295 *3-dimensional radiotherapy plan, including dose-volume histograms* (work RVU= 4.29, intra-service time of 90 minutes and total time of 112 minutes) and noted that the survey code has somewhat less intra-service time and total time and should therefore be valued somewhat lower than the reference code. **The RUC recommends a work RVU of 3.80 for CPT code 7778X4.**

***7778X5 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels***

The RUC reviewed the survey results from 64 radiation oncologists and agreed on the following physician time components: pre-service time of 6 minutes, intra-service time of 100 minutes and post-time of 18 minutes. The RUC noted that a single unit of basic dosimetry (77300) is bundled into the newly created survey code and constitutes 15 minutes of the intra-service time for 7778X1. The specialty explained that the dosimetry calculation is done prior to the patient's arrival and is done on the day of the treatment. The RUC noted that 7778X5 has more intra-service time than 7778X4 primarily due to additional time need to perform the additional channels. This service is a prostate interstitial implant and includes additional post-service time to go over the acute side-effects post-treatment as well as additional instructions for the patient. There are typically two treatments of 7778X5 per patient. There are federal, state and Nuclear Regulatory Commission (NRC) requirements which only permit a radiation oncologist, as authorized user, to perform HDR treatment and require the radiation oncologist to be present at the HDR console during the entire treatment.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 7778X5 and agreed with the specialty that the survey 25<sup>th</sup> percentile work RVU of 5.40 is appropriate for this service. The RUC compared the survey code to CPT code 17313 *Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks* (work RVU=5.56, intra-service time of 100 minutes and total time of 128 minutes) and noted that both services have identical intra-service time and very similar total time and therefore should be valued similarly. Additionally, the RUC compared the survey code to CPT code 77469 *Intraoperative radiation treatment management* (work RVU= 5.75, intra-service time of 90 minutes and total time of 171 minutes) and noted that both services have identical intra-service time, whereas the reference code has more total time, supporting that the survey code should be valued somewhat lower. **The RUC recommends a work RVU of 5.40 for CPT code 7778X5.**

**77295 3-dimensional radiotherapy plan, including dose-volume histograms**

The RUC briefly discussed CPT code 77295, noting that it was last surveyed for the January 2013 RUC meeting. The RUC agreed that the existing RVU and times for this service are appropriate. **The RUC reaffirmed the work RVU of 4.29 for CPT code 77295.**

**77300 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician**

The RUC briefly discussed CPT code 77300, noting that it was last surveyed for the April 2014 RUC meeting. The RUC noted that this service has 15 minutes of intra-service time and one unit of this basic dosimetry service was bundled into each of the 5 survey codes. The RUC agreed that the existing RVU and times for this service are appropriate. **The RUC reaffirmed the work RVU of 0.62 for CPT code 77300.**

**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 reviewed and approved the direct practice expense inputs with the following minor modifications as approved by the Practice Expense Subcommittee:

- The brachytherapy treatment vault (NEW) is included as a direct PE input in the appropriate radiation oncology codes. The PE Subcommittee questioned why this was being proposed rather than the linear accelerator treatment vault and the specialty clarified that the treatment can be performed with a linear accelerator vault, but the new brachytherapy vault is a considerable savings.
- Generally safety kits and transport carts are not included as direct PE inputs, however the specialty explained that the emergency service container/safety kit with transport cart is lead lined and specific to this procedure and cannot be used for any other type of treatment.
- The specialty had added a line item in the pre-service period under other clinical activity. The activity is *prepare afterloader unit for treatment* (line 24). The specialty explained that before the patient can enter the room, the machine must be isolated and secured against the wall. During this activity the physicist removes the HDR unit from vault and positions it in the treatment room. This activity is associated with equipment item, HDR Afterloader System, Nucletron (ER003) on line 113.
- The specialty had recommended 2 minutes and 5 minutes to setup scope (line 32). The PE Subcommittee questioned this because no scope is listed and the specialty explained that this time is needed not to set up a scope but rather to set up remote monitoring and radiation protection equipment. The RUC agreed that this time was appropriate, however to avoid confusion they removed the 2 minutes of clinical staff time to setup a scope in line 32 for CPT codes 7778X1, 7778X2 and 7778X3 and 5 minutes for codes 7778X4 and 7778X5 and added a line item in the pre-service portion of the service period under other clinical activity (line 35).
- For CPT codes 7778X1 and 7778X2 only, it was determined that a clinical staff type of a RN (L051A) is not necessary for detach equipment from patient/implant removal (line 48) and monitor patient following service/check tubes, monitors, drains (not related to moderate sedation) (line 57) and was changed to a RN/LPN/MTA (L037D)



blend (lines 49 and 58). For 7778X3, 7778X4 and 7778X5 the RN remains because bleeding must be controlled and this is out of the scope of practice for a RN/LPN/MTA (L037D) staff type.

- For CPT code 7778X2 only the RUC determined that supply items SA063, SB024 and SB034 are not necessary and they were removed.

The PE Subcommittee had the specialty detail line by line when to clinical staffs are present and if they are working consecutively or concurrently. The equipment minute calculations should be updated to include the appropriate line items based on this discussion.

**Immunofluorescent Studies (Tab 17)**

**Jonathan Myles, MD, (CAP); Michael McEachin, MD, (CAP); Swati Methrota, MD, (ASC); Michael Idowu, MD, (CAP)**

In April 2013, the RUC identified CPT code 88346 through the *CMS/Other source screen* for codes with Medicare utilization over 250,000. The RUC noted that this service was never surveyed but is frequently reported. The specialty society added CPT code 88347 as part of this family. The RUC requested these services be surveyed for work and practice expense review for the September 2014 RUC meeting. In September 2014, the specialty societies indicated, and the RUC agreed, with the need for CPT clarification. CPT codes 88346 and 88347 were referred to the October 2014 CPT Editorial Panel, where the Panel revised CPT code 88346, deleted 88347 and created a new add-on service 8835X0.

***88346 Immunofluorescence- per specimen; initial single antibody stain procedure***

The RUC reviewed the survey responses from 57 pathologists and determined that the survey 25<sup>th</sup> percentile work RVU of 0.74 for CPT code 88346, which is lower than the current work RVU of 0.86, appropriately accounts for the work required to perform the initial single antibody stain procedure. The RUC agreed with the survey respondents that 24 minutes of intra-service time is appropriately relative to other similar services. The RUC compared 88346 to key reference code 88342 *Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure* (work RVU = 0.70 and 25 minutes intra-service time) and determined that 88346 requires similar mental effort, technical skill and physical effort relative to 88342 and should therefore be valued similarly. The immunofluorescence tests are slightly more complex than immunohistochemistry tests because the pathologist is reviewing the Hematoxylin and Eosin stained (H&E) stain first for orient the specimen as there is not background on the fluorescent stain for orientation. For further support, the RUC referenced MPC codes 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU = 0.75) and 76830 *Ultrasound, transvaginal* (work RVU = 0.69). The specialty society noted and the RUC agreed that 88346 is also more complex than 88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation* (work RVU = 0.56) and 88312 *Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)* (work RVU = 0.54) because 88346 is a special technique, based on frozen section tissue which introduces ice artifact which makes interpretation more difficult and there is no counterstain on the immunofluorescent slide for orientation. The immunofluorescence is not performed on the same tissue as the paraffin embedded tissue used for traditional microscopy. Another biopsy must be collected and sent to pathology to be processed in a different way. The tissue is frozen which introduces ice artifact making interpretation more difficult. CPT code 88346 also does not include a counter stain, the pathologist must use a specific microscope that uses fluorescent light and must review the H&E stained slide for orientation.

These additional steps account for the difference between immunofluorescent stain procedures and gram stain procedures. **The RUC recommends a work RVU of 0.74 for CPT code 88346.**

**8835X0 Immunofluorescence- per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)**

The RUC reviewed the survey responses from 54 pathologists and determined that the survey 25<sup>th</sup> percentile work RVU of 0.70 for CPT code 8835X0 appropriately accounts for the work required to perform this service. This service is the same as the base code, 88346, except the physician is performing a different immunofluorescence specimen stain on a different slide for a different antibody. The result from the first stain has no impact on the result of the second stain. The specialty society noted that comparing 8835X0 to CPT code 88341 *Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)* (2015 interim work RVU = 0.42 and April 2014 RUC recommended work RVU = 0.65) is misleading because 88341 currently has an interim value and the specialty society is requesting refinement. Add-on code 88341 is also a separate evaluation of a separate antibody and slide. Any comparison to the work of these immunofluorescent studies services to CMS' valuation of other pathology add-on codes cannot be substantiated by this survey. The specialty societies noted that the survey respondents who chose 88341 as the key reference code indicated that 8835X0 is a more intense and complex service. The specialty noted and the RUC agreed that 8835X0 is very similar to 88346. CPT code 88346 is slightly longer as the physician must review the Hematoxylin and Eosin stained (H&E) slide to determine where and what to look for on the immunofluorescent slide. In the typical case one base code and three add-on codes would be reported. The pathologist would never be reviewing multiple cases simultaneously. The RUC agreed with the survey respondents that 23 minutes of intra-service time is appropriately relative to other similar services. The RUC noted that 8835X0 requires only 1 minute less to perform than base code 88346 and the survey respondents have placed these services in the proper rank order. The RUC compared 8835X0 to key reference code 88342 *Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure* (work RVU = 0.70 and 25 minutes intra-service time) and noted that 8835X0 requires similar intensity and complexity and should therefore be valued similarly. For further support, the RUC referenced MPC codes 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU = 0.75) and 76830 *Ultrasound, transvaginal* (work RVU = 0.69). **The RUC recommends a work RVU of 0.70 for CPT code 8835X0.**

**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 reviewed and approved the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee. Some of the modifications include:

- The clinical staff time for prepare, pack and transport specimens and records for in-house storage and external storage (where applicable) (line 42), clean equipment and work station in histology lab and cryostat (line 44) and recycle xylene from stainer (line 46), is only needed in the base code, CPT code 88346, and not in the add-on code, CPT code 8835X0.
- For CPT code 88346 the clinical staff time for file worksheets and results (line 48) was removed.

**Vestibular Caloric Irrigation (Tab 18)**

**Peter Manes, MD (AAO-HNS)**

In October 2013 the RUC identified CPT code 92543 through the CMS-Other Source – Utilization over 250,000 screen and referred this issue to the CPT Editorial Panel to revise the parentheticals prior to surveying the family (CPT codes 92541-92545). In February 2014, the CPT Editorial Panel added and revised the parenthetical notes for CPT code 92270 *Electro-oculography with interpretation and report* and vestibular function tests to ensure appropriate reporting of these services. The RUC agreed that the vestibular function tests (92541-92545) be reviewed following the CPT modification to the parenthetical notes.

In April 2014, after reviewing the survey results, the RUC agreed with the specialty societies that the code descriptor was unclear. The RUC recommended referring CPT code 92543 to the CPT Editorial Panel to better define this service, (See April 2014 RUC Recommendations attached). In October 2014, the CPT Editorial Panel deleted CPT code 92543 and created two new CPT codes to report caloric vestibular testing for monothermal and bithermal testing procedures.

Prior to reviewing these services, the RUC discussed compelling evidence that the current RVU may be misvalued. First, the specialties explained that the current work value for 92543 is derived from a Harvard-valued code based on a different specialty than the current typical provider, audiologists. Furthermore, incorrect assumptions and a flawed methodology have been made with the current value. In 2009, vestibular codes 92541, 92542, 92544 and 92545 were bundled and valued through the RUC process, resulting in CPT 92540 (Basic vestibular evaluation). However, during that process, the audiology clinical staff time was removed, not only from the new bundled code, but also from each of the individual component codes without having gone through the RUC process. The RUC accepted compelling evidence that the current work RVUs may be misvalued.

***9254X1 Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)***

The RUC reviewed the survey results for 133 audiologists, neurologists and otolaryngologists and agreed with the following physician time components: pre-service time of 5 minutes, intra-service time of 30 minutes and post-service time of 5 minutes. The specialties noted that the pre and post service times, which are 5 minutes respectively, represent the time it takes to prepare the irrigation test equipment, calibrate the patient with the testing equipment and place the patient in the correct position. Also since many patients are hearing impaired and cannot wear their hearing aids during the procedures, time is needed in both the pre and post periods for instruction and explanation of results. The specialty also explained, and the RUC agreed, that the recommended pre and post-service times for 9254X1 represent specific equipment preparation, calibration and positioning needed to prepare for the caloric vestibular testing, and are separate and distinct from the pre and post-service times of other vestibular codes. In response to a question by the RUC the specialty explained that interpretation and report, which is typically associated with imaging codes, is different than “documentation” and that diagnostic interpretation and report is appropriately located in intra-service work. Finally, the RUC noted that the procedure used to be reported once per irrigation but is now reported once per session. They also noted that the typical patient has four irrigations per session. The specialty also explained that CPT 92540, which describes basic vestibular evaluation, is often reported in conjunction with this procedure. Based on

these explanations, the RUC agreed that the 25<sup>th</sup> percentile work value of 0.80 accurately represents the typical physician work of this procedure.

To further justify a work RVU of 0.80 for 9254X1, the RUC reviewed CPT code 99366 *Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional* (work RVU= 0.82, intra-service time of 30 minutes), and agreed that with identical time and similar work they should be valued similarly. The RUC also compared the surveyed code to 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), and agreed that the service has more total time and is slightly more intense to perform, which accounts for the slightly higher work value. **The RUC recommends a work RVU of 0.80 for CPT code 9254X1.**

**9254X2 Caloric vestibular test with recording, bilateral; monothermal (ie, one irrigation in each ear for a total of two irrigations)**

The RUC reviewed the survey results for 103 audiologists, neurologists and otolaryngologists and agreed with the following physician time components: pre-service time of 5 minutes, intra-service time of 15 minutes and post-service time of 5 minutes. The specialties noted that the pre and post service times, which are 5 minutes respectively, represent the time it takes to prepare the irrigation test equipment, calibrate the patient with the testing equipment and place the patient in the correct position. Also since many patients are hearing impaired and cannot wear their hearing aids during the procedures, time is needed in both the pre and post periods for instruction and explanation of results. The specialty also explained, and the RUC agreed, that the recommended pre and post-service times for 9254X2 represent specific equipment preparation, calibration and positioning needed to prepare for the caloric vestibular testing, and are separate and distinct from the pre and post-service times of other vestibular codes. In response to a question by the RUC the specialty explained that interpretation and report, which is typically associated with imaging codes, is different than “documentation” and that diagnostic interpretation and report is appropriately located in intra-service work. Finally, the RUC noted that the procedure used to be reported once per irrigation but it now reported once per session. They also noted that the typical patient for 9254X2 has two irrigations per session. In contrast to the patient that receives four irrigations, the typical patient for 9254X2 is often more acutely ill and has additional co-morbidities that increase the intensity/complexity of the testing process. The specialty also explained that CPT 92540, which describes basic vestibular evaluation, is often reported in conjunction with this procedure. Based on these explanations, the RUC agreed that the 25<sup>th</sup> percentile work value of 0.55 accurately represents the typical physician work of this procedure.

To further justify a work RVU of 0.55 for 9254X2, the RUC reviewed CPT code 92570 *Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing* (work RVU=0.55, intra-service time of 15 minutes) , as well as CPT code 96119 *Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face* (work RVU=0.55, intra-service time of 15 minutes) , and agreed that with identical work and intra-service time the surveyed code should be valued identically. **The RUC recommends a work RVU of 0.55 for CPT code 9254X2.**

### **Practice Expense**

The RUC reviewed and approved the direct practice expense inputs with no modifications as submitted by the specialty society and approved by the Practice Expense Subcommittee. The RUC notes the following:

- There has been a change in technology and clinical practice for these services. The ENG equipment previously used for these services has been replaced with VNG equipment.
- CPT codes 9254X1 and 9254X2 were surveyed for work based on infrared goggles (VideoOG or VNG), which have replaced surface electrodes (ENG) as the clinical standard for vestibular testing. Therefore, adjustments have been made to account for VNG technology, including addition of new VNG equipment to replace ENG equipment. The same adjustments were made to other vestibular testing codes (92541-42, 92544-45) at the April 2014 meeting.
- Over the last 10 years, technology has evolved and clinical practice has changed such that infrared video goggles (VideoOG or VNG) have replaced surface electrodes (ENG), which was the previous clinical standard. According to a leading manufacturer of vestibular testing equipment, in 1985 when the vestibular function codes were valued as part of the Harvard study, ENG (electrode based) equipment made nearly 100% of sales. VNG recording was introduced in 1997. As of 2012, 61% of equipment sold is solely video based, and 39% has ENG as an optional add on. No new electrode-only systems have been sold since 2009.
- Current CPT code 92543 *Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording* is valued for a single irrigation whereas new codes 9254X1 and 9254X2 are valued based on four (4) and (2) irrigations, respectively. As such, the minutes of equipment usage will be increased for the new codes and are submitted in line with the work median intra-time for each code.

## **XI. CMS Request/Relativity Assessment Identified Codes**

### **Bone Biopsy Excisional (Tab 19)**

**William Creevy MD, (AAOS); John Heiner MD, (AAOS); Tim Tillo DPM, (APMA)**

In January 2014, the RUC reviewed 010-day global services (based on 2012 Medicare utilization data) and identified 18 services with greater than 1.5 office visits and 2012 Medicare utilization greater than 1,000. The RUC requested these services be surveyed for work and review the practice expense for the September 2014 RUC meeting. In September, the RUC requested and CMS approved to change the global period from a 010-day global to a 000-day global for both CPT code 20240 and 20245 and the specialty societies presented survey data at the January 2015 meeting.

Prior to reviewing CPT code 20240, the specialty society presented compelling evidence that the work value for CPT code 20240 may be misvalued. The specialty noted that incorrect assumptions were made in the previous valuation of the service. The current intra-service time is based on a Harvard study of 8 general surgeons, while the pre- and post-service times were derived from an algorithm. Furthermore, the Harvard survey of general surgeons no longer represents the dominant provider, which is now podiatry. The RUC agreed with the

specialty societies that there is compelling evidence that CPT code 20240 is potentially misvalued.

**20240 Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur)**

The RUC reviewed the survey responses from 71 podiatrists and orthopaedic surgeons and recommend the following physician time components: pre-service time of 58 minutes, intra-service time of 30 minutes and immediate post-service time of 30 minutes. The RUC agreed that an additional 7 minutes of positioning time above the standard pre-service time package 3 (straightforward patient, difficult procedure) to place the patient in the prone position with attention to padding and tourniquet application prior to the procedure.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the 25<sup>th</sup> percentile work RVU of 3.73 accurately values the physician work of CPT code 20240. To justify a work RVU of 3.73, the RUC compared the surveyed code to the key reference code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10) and noted that the reference code has more intra-service time, 45 minutes compared to 30 minutes, and is correctly valued higher than code 20240. The RUC also reviewed MPC codes 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands* (work RVU= 3.50, intra-service time= 30 minutes) and 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-service time 30 minutes) and agreed that the recommended value for 20240 accurately fits between these two reference services. The RUC considered 13 recently reviewed 0-day global codes with 30 minutes of intra-operative time and noted that a majority of these codes are endoscopies (through a natural orifice) or percutaneous procedures through a vessel. These 13 0-day global codes provided additional support for the recommendation of 3.73 work RVUs for code 20240 as it transitions to a 0-day global period. **The RUC recommends a work RVU of 3.73 for CPT code 20240.**

**20245 Biopsy, bone, open; deep (eg, humerus, ischium, femur)**

During the discussion of CPT code 20245, the RUC noted several issues with the survey data. The specialty society explained that the survey sample was limited to a random sample of physician members of the Musculoskeletal Tumor Society (MSTS). This specialty was chosen since physicians in this society are more likely to perform this service than general orthopaedic surgeons. The RUC raised two concerns with this approach. First, the RUC was uncomfortable that the surveying specialties did not get Research Subcommittee approval to selectively target only members of the MSTS. Second, there were questions about the typical patient for this service. While the vast majority of survey respondents indicated that the typical patient has cancer, the Medicare 5% sample file does not indicate identification of a malignant lytic lesion as any of the top diagnosis codes billed with 20245. Therefore, it was unclear whether or not the correct survey population was chosen.

In addition, the specialty societies indicated discomfort that this newly created 000-day global period service (previously 090-day) did not accurately value the work of the discharge day management service due to the use of the standard 000-day survey template. **The RUC agreed that CPT code 20245 should be referred to Research Subcommittee to approve a new survey sample which will incorporate a more general population and consider changes to the 000-day global survey template to better value the work of this major**

**procedure. The specialty societies will present survey data at the April 2015 RUC meeting.**

**Practice Expense**

The RUC reviewed and approved the direct practice expense inputs with no modifications as submitted by the specialty society and approved by the Practice Expense Subcommittee. The RUC notes the following:

- The RUC standard for 000-day and 010-day day codes is no pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that 30 minutes for facility-based procedures may apply to a select number of codes that require extensive use of clinical staff time. Although these two codes are transitioning to 000-day global assignment, both 20240 and 20245 are major procedures performed under general anesthesia. The specialty recommended and the RUC agreed that 30 minutes pre-service clinical staff work is justified.

**Repair Flexor Tendon (Tab 20)**

**Anne Miller, MD (ASSH); William Creevy, MD (AAOS); Martha Matthews, MD (ASPS)**

In January 2014, the RUC reviewed 090-day global services (based on 2012 Medicare utilization data) and identified 10 services, reported at least 1,000 times per year that included more than 6 office visits. The RUC requested these services be surveyed for work and review the practice expense for the January 2015 RUC meeting.

The specialty societies explained that they did not submit survey data for CPT codes 26356, 26357 and 26358 at the January 2015 RUC meeting due to concern over the CMS final decision to transition all surgical codes with a 010- and 090-day global period to 000-day global. Specifically, the specialties were concerned that CMS, as they did to several codes in the 2015 Final Rule, would choose to use the reverse building block methodology to calculate a 0-day global value. The RUC noted that CMS has been clear that they will still accept RUC recommendations for surgical global codes which cannot adequately be surveyed, at this time, as 000-day globals. The RUC reiterated its clear position that given that CPT code 26356 was identified through the RAW process under the 090-day global post-operative visit screen, the current potentially misvalued code review cannot stop as a long-term strategy is formed to address the surgical global transition. **Therefore, the RUC recommends that survey data be presented for CPT codes (26356, 26357 and 26358) at the April 2015 RUC Meeting.**

**Correction of Bunion (Tab 21)**

**Timothy H. Tillo, DPM (APMA)**

In January 2014, the RUC reviewed 090-day global services (based on 2012 Medicare utilization data) and identified 10 services, reported at least 1,000 times per year that included more than 6 office visits. CPT code 28293 was identified and the specialty societies added 28290-28299 as part of the family of services. The RUC requested these services be surveyed for work and review the practice expense for the January 2015 RUC meeting.

The specialty societies indicated that after reviewing the vignettes and the bunionectomy code descriptors, CPT coding changes are necessary, including deletion of code(s), possible

bundling of codes, and general descriptor revisions. **The specialty societies requested and the RUC recommends CPT codes 28290-28299 are referred to the CPT Editorial Panel for revision.**

**Ocular Reconstruction Transplant (Tab 22)**

**Michael X. Repka, MD (AAO); Stephen A. Kamenetzky, MD (AAO); John T. Lanza, MD (AAO – HNS)**

In January 2014, the RUC reviewed 090-day global services (based on 2012 Medicare utilization data) and identified 10 services, reported at least 1,000 times per year that included more than 6 office visits. The RUC requested these services be surveyed for work and review the practice expense for the January 2015 RUC meeting.

The specialty societies explained that they did not submit survey data for CPT codes 65780 at the January 2015 RUC meeting due to concern over the CMS final decision to transition all surgical codes with 010- and 090-day global period to 000-day globals. Specifically, the specialties were worried that CMS, as they did to several codes in the 2015 Final Rule, would choose to use the reverse building block methodology to value the 090-day globals as 000-day globals. The RUC noted that CMS has been clear that they will still accept RUC recommendations for surgical global codes which cannot adequately be surveyed, at this time, as 000-day globals. The RUC reiterated its clear position that given that CPT code 65780 was identified through the RAW process under the 090-day global post-operative visit screen, the current potentially misvalued code project cannot stop as a long-term strategy is formed to address the surgical global transition. **Therefore, the RUC recommends that survey data be presented for CPT codes (65780) at the April 2015 RUC Meeting.**

**Dilation and Probing of Lacrimal Nasolacrimal Duct (Tab 23)**

**Stephen A. Kamenetzky, MD, (AAO); and David B. Glasser, MD, (AAO)  
Charlie Fitzpatrick. OD (AOA)**

In January 2014, the RUC reviewed 010-day global services (based on 2012 Medicare utilization data) and identified 18 services with >1.5 office visits and 2012 Medicare utilization > 1,000. CPT codes 68801, 68810 and 68815 were surveyed for work and the practice expense was reviewed for the September 2014 RUC meeting. However, the RUC agreed that CPT codes 68811 and 68816 are also part of this code family and were left off in error. The RUC requested that the specialty re-survey with the appropriate survey instrument for the January 2015 RUC meeting.

***68801 Dilation of lacrimal punctum, with or without irrigation***

The RUC reviewed the survey results from 55 ophthalmologists and optometrists and agreed on the following physician time components: pre-service time of 7 minutes (with 14 minutes less evaluation time, 1 minute of additional positioning time and 3 minutes less scrub, dress and wait time relative to the standard 6A pre-time package), intra-service time of 5 minutes and immediate post-service time of 5 minutes (post-service package 7A minus 13 minutes). The pre-time was reduced relative to the standard package, as this service is typically done in the office setting in conjunction with a separate E/M visit. The pre-service time includes 2 minutes to allow for positioning of the conscious patient and 2 minutes for the administration of topical anesthesia. The RUC agreed with the specialty that one 99212 office visit during the 010-day global period is justified in order to examine the patient and see if there is patency of the lacrimal system.



The RUC reviewed the survey 25<sup>th</sup> percent work RVU of 1.10 and agreed with the specialty societies that the current value of 1.00 is appropriate for this service. The RUC compared the survey code to CPT code 64611 *Chemodenervation of parotid and submandibular salivary glands, bilateral* (work RVU= 1.03, 5 minutes of intra-service time, 36 minutes of total time) and noted that since the codes have identical intra-service times, the same number and level of office visits, and similar total times, the similar work values are justified. Additionally, the RUC compared the survey code to CPT code 65778 *Placement of amniotic membrane on the ocular surface; without sutures* (work RVU= 1.19, 5 minutes of intra-service time and 31 minutes of total time) and noted that the survey code has identical intra-service times, the same number and level of office visits, and a similar total time, and is therefore, correctly valued similarly to 65778.

The RUC observed that the previous time data resulted in a negative IWPUT, so maintaining the work RVU, while using the new survey times addresses this anomaly. **The RUC recommends a work RVU of 1.00 for CPT code 68801.**

**68810 Probing of nasolacrimal duct, with or without irrigation;**

The RUC reviewed the survey results from 44 ophthalmologists and optometrists and agreed on the following physician time components: pre-service time of 12 minutes, with 12 minutes less evaluation time and 1 minute of additional positioning time relative to the standard 6A pre-time package, intra-service time of 10 minutes and immediate post-service time of 5 minutes (post-service package 7A minus 13 minutes). The pre-time was reduced relative to the standard package, as this service is typically done in the office setting in conjunction with a separate E/M visit. The pre-service time is greater than for 68801, because the eye and nasolacrimal system takes longer to anesthetize and position the patient to be able to pass the probe comfortably. The pre-service time includes 2 minutes to allow for positioning of the conscious patient and 5 minutes for the administration of topical anesthesia. The RUC agreed with the specialty that one 99212 office visit during the 010-day global period is justified in order to examine the patient and see if there is patency of the lacrimal system.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25<sup>th</sup> percentile work RVU of 1.54 is appropriate. The RUC compared the survey code to top key reference code 68840 *Probing of lacrimal canaliculi, with or without irrigation* (work RVU= 1.30, intra-service time of 10 minutes and total time of 39 minutes) and noted that both codes have identical intra-service time, whereas the survey code has a longer total time, justifying a somewhat higher RVU. Additionally, the RUC compared the survey code to CPT code 64615 *Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)* (work RVU= 1.85, pre-service time of 15 minutes, intra-service time of 15 minutes and post-service time of 5 minutes) and noted that the reference code has more intra-service, whereas the survey code has a longer total time, justifying a somewhat lower RVU for the survey code. **The RUC recommends a work RVU of 1.54 for CPT code 68810.**

**68811 Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia**

The RUC reviewed the survey results from 30 ophthalmologists and agreed on the following physician time components: pre-service time of 25 minutes (standard 1b pre-time package), intra-service time of 10 minutes and immediate post-service time of 13.5 minutes (post-service package 9A minus 16.5 minutes). The pre-service time is greater than for 68810 because, unlike 68810, is not performed in conjunction with a separate E/M and the

procedure is performed in a facility under general anesthesia. The RUC agreed with the specialty that a ½ day discharge visit (99238) is appropriate for this procedure that is typically performed in a facility. The RUC also concurred with the specialty that one 99211 office visit during the 010-day global period is justified in order to examine the patient and see if there is patency of the lacrimal system. The patient is typically a young child, which also contributes to the added complexity.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the survey median work RVU of 2.03 is appropriate. The RUC compared the survey code to top key reference code 68840 *Probing of lacrimal canaliculi, with or without irrigation* (work RVU= 1.30, intra-service time of 10 minutes and total time of 39 minutes) and noted that both codes have identical intra-service time, whereas the survey code has almost twice as much total time, justifying a higher RVU. Additionally, the RUC compared the survey code to MPC code 11641 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm* (work RVU= 2.17, pre-service time of 15 minutes, intra-service time of 20 minutes and post-service time of 5 minutes) and noted that the survey code has lower intra-service time, and is therefore, appropriately valued somewhat lower than 11641. **The RUC recommends a work RVU of 2.03 for CPT code 68811.**

**68815 *Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent***

The RUC reviewed the survey results from 63 ophthalmologists and ocular plastic surgeons and agreed with the specialty on the following physician time components: pre-service time of 25 minutes (standard pre-time package 1B), intra-service time of 20 minutes and post-service time of 12 minutes (post-time package 9A minus 18 minutes). The RUC acknowledged that like 68811, this service is typically done in a facility, not with a separate E/M visit and under general anesthesia. The societies subtracted 18 minutes from the standard post-time package in order to match the survey results. The RUC agreed with the specialty that a ½ day discharge visit (99238) is appropriate for this procedure that is typically performed in a facility. The RUC also concurred that two 99212 office visit during the 010-day global period are justified in order to reflect the increased complexity of managing the patient with the stent in place. The patient is typically a young child, which also contributes to the added complexity.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the median work RVU of 3.00 is appropriate. The RUC compared the survey code to CPT code 58120 *Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)* (work RVU= 3.59, intra-service time of 25 minutes and total time of 129 minutes) and noted that since the survey code has a lower intra-service time and less total time (116 minutes vs. 129 minutes), a somewhat lower work RVU for the survey code is justified. Additionally, the RUC compared the survey code to MPC code 11623 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* (work RVU= 3.11, intra-service time of 30 minutes and total time of 93 minutes) and noted that with less intra-service time, though more total time, the survey code is appropriately valued comparably to MPC code 11623. **The RUC recommends a work RVU of 3.00 for CPT code 68815.**

**68816 Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation**

The RUC reviewed the survey results and agreed on the following physician time components: pre-service time of 25 minutes (standard 1B pre-time package), intra-service time of 20 minutes and immediate post-service time of 12 minutes (post-service package 9A minus 18 minutes). The RUC acknowledged that like 68811 and 68815, this service is typically done in a facility, not with a separate E/M visit and under general anesthesia. This code is similar in work to 68811 but takes more time because of the need to cycle the inflation and deflation of the balloon to relieve the obstruction. The RUC agreed with the specialty that a ½ day discharge visit (99238) is appropriate for this procedure that is typically performed in a facility. The RUC also concurred that one 99211 office visit during the 010-day global period is justified.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey median work RVU of 2.35 is appropriate. The RUC compared the survey code to MPC code 11641 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm* (work RVU= 2.17, pre-service time of 15 minutes, intra-service time of 20 minutes and post-service time of 5 minutes) and noted that the services have identical intra-service time, though the survey code has higher total time, and is therefore, appropriately valued somewhat higher than 11641. Additionally, the RUC compared the survey code to MPC code 11623 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* (work RVU= 3.11, intra-service time of 30 minutes and total time of 93 minutes) and noted that with less intra-service time and total time, the survey code is appropriately valued less compared to MPC code 11623. **The RUC recommends a work RVU of 2.35 for CPT code 68816.**

**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 reviewed and approved the direct practice expense inputs with the following modifications as approved by the Practice Expense Subcommittee:

- The RUC standard for 0 and 10 day codes is no pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that a pre-service standard time allocation of 18 minutes for the non-facility and 30 minutes for facility based procedures may apply to a select number of codes. The specialty determined and the RUC agreed that these services require extensive use of clinical staff time in the facility setting. The services require some subset of the 18 minutes for extensive use of clinical staff time in the nonfacility setting.
- The quantity of supply item lidocaine 2% w-epi Inj (zylocaine w-epi) ml (SH049) was revised to 5 for CPT codes 68810, 68815 and 68816 only (line 73).
- The specialty revised all equipment minute calculations to include the appropriate line items, with the understanding that the equipment minute calculations should not include post-operative visit time for items only used during the procedure, such as basic surgical pack (EQ137) and design for vision loupes (EQ176) in CPT code 68801.
- Equipment time for the light, surgical (EF014) was removed from CPT code 68816, since a light source is already available in equipment item Fiberoptic Exam Light w/ source (EQ170).

## **XII. CMS Request – Final Rule for 2014/Proposed Rule for 2015:**

### **Implantation of Neuroelectrodes – PE Only (Tab 24)**

**Marc Leib, M.D. (ASA); Richard Rosenquist, M.D. (ASA); Alexander Mason, M.D. (CNS); John Ratliff, M.D. (AANS); Karin Swartz, M.D. (NASS); Kano Mayer, M.D. (NASS); Eduardo Fraifeld, M.D. (AAPM); David Lenrow, M.D. (AAPM&R); Victor Chang, M.D. (AAPM&R)**

CMS indicated that a stakeholder raised questions regarding whether codes 64553 and 64555 included the appropriate direct PE inputs when furnished in the non-facility setting. It appears that these inputs have not been evaluated recently and therefore CMS nominated these codes as potentially misvalued for the purpose of ascertaining whether or not there are non-facility direct PE inputs that are not included in the direct PE inputs that are typical supply costs for these services. In September 2014, the RUC recommended that these services be reviewed for direct practice expense only at the January 2015 meeting. However in the Final Rule for 2015, CMS requested that the work and direct PE inputs be reviewed. In order for work and direct PE inputs to be reviewed together the specialty societies indicated they will survey for April 2015. **Therefore, the RUC recommends that survey and practice expense data be presented for CPT codes (64554 and 64555) at the April 2015 RUC Meeting.**

### **Echo Guidance for Ova Aspiration (Tab 25)**

**George A. Hill, MD**

In the Final Rule for 2014, CMS stated, “the Agency believes that the discrepancy in procedure times and the resulting potentially inaccurate payment raises a fundamental concern regarding the incentive to furnish ultrasound guidance. However, CMS believes this concern spans more than just an individual code for ultrasound guidance.” Accordingly, CMS has requested additional ultrasound guidance codes as potentially misvalued. CMS is seeking public comment on including these codes as potentially misvalued codes. The specialty societies brought forward an action plan for CPT code 76948 *Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation* at the September 2014 RUC meeting and the RUC recommended that this service be surveyed for work and review direct practice expense inputs at the January 2015 meeting.

### ***76948 Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation***

CPT Code 76948 is a “CMS other” code that has never been surveyed and the factors that went into valuing this code are not defined. The specialty society notes that current CMS times do not reflect current practice and are inherently flawed. Additionally, the specialty society noted that CPT Code 76948 has an anomalous relationship with other similar ultrasound codes. The physician time, technical skill, site of service and patient severity are similar for codes 76948, 76945 *Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation* (work RVU = 0.67 and 30 minutes total physician time), 76830 *Ultrasound, transvaginal* (work RVU = 0.69 and 23 minutes total physician time) and 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 31 minutes total physician time). However, the current value of 0.38 and physician time of 15 minutes for CPT code 76948 is approximately half that of the actual physician work and time required to perform this service and the aforementioned services, causing a rank order anomaly. The RUC agreed that the

original valuation of CPT code 76948 was flawed and there is compelling evidence to reconsider this service.

The RUC reviewed survey responses from 86 physicians and determined that the survey 25<sup>th</sup> percentile work RVU of 0.85 appropriately accounts for the work required to perform CPT code 76948. The RUC recommends: 3 minutes pre-service evaluation time, 25 minutes intra-service time and 3 minutes immediate post-service time. The RUC compared 76948 to MPC codes 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 31 minutes total physician time) and 74280 *Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon* (work RVU = 0.99 and 32 minutes total physician time) and noted that these services require similar physician work and time to perform. The RUC also compared 76948 to key reference service 76945 *Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation* (work RVU = 0.67) and 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (work RVU = 0.67) and noted both require less physician work. CPT code 76948 requires multiple follicle punctures whereas 76945 and 76942 require one single needle placement. The RUC agreed that 76848 is appropriately valued compared to these reference services. **The RUC recommends a work RVU of 0.85 for CPT code 76948.**

#### **Practice Expense**

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

- In order to avoid confusion and to better describe the work of the clinical staff during the intra-service portion of the service period line 32 was revised to read perform u/s imaging (line 32).
- Two items that are clinical necessary for the procedure were inadvertently overlooked and the PE Subcommittee determined that it was appropriate to add cover-condom, transducer or ultrasound probe (SB005) and guide, needle, for localization (SD087).
- The equipment minute calculation for ultrasound unit, portable (EQ250) was updated to include the appropriate line items.

### **XIII. Practice Expense Subcommittee (Tab 26)**

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

- The Practice Expense (PE) Subcommittee completed its review of very expensive equipment pricing. As you may recall we raised the question, is there is an incentive for societies to bring very expensive equipment and supplies for review as an unintended consequence of RAW screens. There were only a small number of items, predominantly radiology and radiation oncology. RUC staff queried the RUC database for these expensive items, looking at when they had been reviewed and displaying the utilization to determine what the impact would be. In reviewing the data, the PE Subcommittee observed that if you look at the top 20-30 codes with the greatest impact, respectively more than a million PE RVUs and more than 500,000 PE RVUs, the RUC has already recently reviewed most of the high impact (PE RVU multiplied by utilization) codes in

recent years. After some discussion the PE Subcommittee determined that it has done its due diligence in reviewing and making the appropriate adjustments to high impact services through its current process. The PE Subcommittee determined that no further action on this issue is needed at this time.

- As discussed during this meeting regarding the penile trauma codes, the PE Subcommittee discussed what we do for pre-service clinical staff time for emergent procedures. Examples of this are the emergent repair of a ruptured aortic aneurysm which has the full 60 minutes of pre-service clinical staff time for a standard 90 day global as compared to the emergent appendectomy codes which only have 15 minutes of pre-service clinical staff time. The aneurysm was based on decisions from 2000 versus the appendectomy codes in 2010 and as recently as 2014. Given the range of variable responses over time, rather than make a systematic decision at this time we are going to research the issue. We will identify emergent codes, take a look at what has been done in the past and develop a work plan at the next meeting.

### **The RUC approved the Practice Expense Subcommittee Report**

#### **XIV. Administrative Subcommittee (Tab 27)**

Doctor Michael Bishop, Chair, provided a summary of the Administrative Subcommittee report:

- **Financial Disclosure – Clinical Trial Involvement**  
Doctor Bishop reported to the RUC that the Administrative Subcommittee reviewed the Financial Disclosure statement and discussed adding a sentence to identify presenters who participated in clinical trials that involve the codes under review. The Administrative Subcommittee determined it is necessary to have physicians involved in clinical trials for the services being reviewed by the RUC, which they have received material income be identified as part of the current financial disclosure statement. **The Workgroup recommended revising the financial disclosure statement to the following:**

#### **AMA/Specialty Society RVS Update Committee (RUC) Financial Disclosure Statement For Specialty Society Presenters**

I certify that my personal or my family members' direct financial interest in, and my personal or my family members' affiliation with or involvement in any organization or entity with a direct financial interest in the development of relative value recommendations in which I am participating are noted below. Otherwise, my signature indicates I have no such direct financial interest or affiliation with an organization with a direct financial interest, other than providing these services in the course of patient care.

For purposes of this disclosure "direct financial interest" means:

- A financial ownership interest in an organization\*\* of 5% or more; or
- A financial ownership interest in an organization\*\* which contributes materially\*\*\* to your income; or
- Ownership of stock options in an organization\*\*;
- A position as proprietor, director, managing partner, or key employee in an organization\*\*;
- Serve as a consultant, researcher, expert witness (excluding professional liability testimony), speaker or writer for an organization\*\* **or participate in a clinical trial that involves the services being reviewed**, where payment contributes materially\*\*\* to your income.

*\*Family member means spouse, domestic partner, parent, child, brother or sister. Disclosure of family member's interest applies to the extent known by the representative or presenter..*

*\*\* Organization means any entity that makes or distributes the product that is utilized in performing the service, and not the physician group or facility in which you work or perform the service.*

*\*\*\*Materially means \$10,000 or more in income (excluding any reimbursement for expenses) for the past twenty-four months.*

**Include only interests that relate to the specific issue that you are presenting at this RUC meeting.**

Specific Disclosure (i.e., list organization)	Explain relationship between the service(s) that you are presenting and your disclosure	Identify interest for the past 24 months (circle one)	Identify cumulative lifetime interest (circle one)	If disclosure relates to stock, please list number of shares owned, options or warrants
		N/A < \$10,000 ≥ \$10,000	< \$10,000 ≥ \$10,000	

- **Disclosures from RUC Participants/Audience**

Doctor Bishop noted that in September 2014, the RUC requested that the Administrative Subcommittee consider conflicts for individuals that speak to issues from the audience a RUC meetings. The Subcommittee noted that currently when participants from the audience speak at the microphone, they introduce themselves and announce any conflicts of interest/financial interests in the codes being reviewed before they make a statement. The Subcommittee discussed that participants who intend to speak at the microphone should be aware of what the RUC constitutes as a conflict of interest or financial interest prior to speaking at a RUC meeting. **The Administrative Subcommittee recommends identifying the financial disclosure policy on the confidentiality statement the participants sign at the registration desk. AMA staff will draft a revised confidentiality statement for review at the April 2015 meeting.**

**The RUC approved the Administrative Subcommittee Report.**

## **XV. HCPAC Review Board (Tab28)**

Anthony Hamm, DC, provided the Health Care Professionals Advisory Committee Review Board report:

### **Excision of Nail Bed (11752)** **Timothy Tillo, DPM (APMA)**

In January 2014, the RUC reviewed 010-day global services (based on 2012 Medicare utilization data) and identified 18 services with >1.5 office visits and 2012 Medicare utilization data over 1,000. CPT codes 11750 and 11752 were identified by the RAW 010-day global post-operative visit screen with more than one post-op visit identified in the database. The RUC requested these services be surveyed for work and review the practice expense for the September 2014 RUC meeting.

### ***11750 Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;***

The HCPAC reviewed the survey results from 83 podiatrists. The HCPAC determined that the survey 25<sup>th</sup> percentile work RVU of 1.99 for CPT code 11750, which is 20% less than the

current work RVU, is appropriate. The HCPAC compared 11750 to key reference code 10061 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU = 2.45 and intra-service time of 25 minutes) and determined that 10061 requires more work and time. The HCPAC requested and the specialty society agreed to remove 2 minutes of pre-service evaluation time. The HCPAC referenced MPC codes 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 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU= 2.29) and determined the survey 25<sup>th</sup> percentile work RVU of 1.99 appropriately accounts for work and time to perform this service. As additional support, the HCPAC compared 11750 to other recently reviewed codes with 15 minutes of intra-service time and recently reviewed codes with similar intra-service work intensity and determined that a work RVU of 1.99 is an appropriate relative value. **The HCPAC recommends a work RVU of 1.99 for CPT code 11750.**

***11752 Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal; with amputation of tuft of distal phalanx***

The American Podiatric Medical Association (APMA) submitted a request and the HCPAC agreed to table CPT code 11752 until the January 2015 RUC meeting. This allowed the specialties that perform this service to determine whether code 11752 should be deleted or requires some other CPT action which could include a RUC survey with all physicians and health care professionals that perform this service. In January 2015, the APMA submitted a letter to the HCPAC review board indicating that the code be referred to the CPT Editorial Panel. In discussions with other specialties (orthopedic surgery and hand surgery), it was determined that this code should correctly be reported for crush injuries of the tip of a digit, requiring removal of nail and amputation of bone. **The RUC HCPAC Review Board recommends that code 11752 be sent to CPT for clarification and revision to reflect current practice and correct coding.**

**Practice Expense**

The HCPAC accepted the direct practice expense inputs as approved by the PE Subcommittee.

**The RUC filed the HCPAC Review Board Report.**

**XVI. Relativity Assessment Workgroup (Tab 29)**

Doctor Raphaelson provided a summary of the Relativity Assessment Workgroup meeting.

**Joint CPT/RUC Workgroup on Codes Reported Together Frequently – Progress Report**

Doctor Raphaelson noted that Kenneth Brin, MD, Chair of the Joint Workgroup, provided a summary of the Workgroup's review of the fourth iteration of the bundled services project. Seven groups of services have been identified. The Joint Workgroup recommended and the Relativity Assessment Workgroup agreed that for three groups coding proposals for the 2017 CPT cycle should be submitted; one group is not appropriate to bundle; one groups action plan will be further reviewed at the next Joint Workgroup meeting; and two groups will be reviewed again after utilization data is available once current coding changes take effect.



**New Technology/New Services Review (37 codes/21 code families)**

Doctor Raphaelson indicated that the Workgroup reviewed 37 codes or 21 families of services of services that were flagged as new technology and recommend that six services be surveyed and review one action plan for April 2015, review 11 services after additional utilization data is available and remove the remaining codes from the list as no technology diffusion that impacts work or practice expense was apparent. **The full list is in the report attached to these minutes.**

**Work Neutrality Review (CPT 2012)**

Doctor Raphaelson announced that AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2012 cycle. It appeared that there were two issues where there was a large growth in utilization in the first year, Chronic Wound Dermal Substitute and Destruction by Neurolytic Agent. The Chronic Wound Dermal Substitute family of codes, 15271-15278 was identified in error. This family of services was work neutral as submitted. AMA staff provided the correct source data and work neutrality assumptions for Chronic Wound Dermal Substitute services to file for informational purposes. The second family, CPT codes 64633-64636, showed that in the year 2012 the Destruction by Neurolytic Agent codes was not budget work neutral and that, during the first year of the code's existence, there was 24% more utilization than projected. Therefore, the Relativity Assessment Workgroup review was initiated for this family.

The specialty societies have indicated in their action plan that the utilization numbers for this family of codes are climbing despite the fact that each code now describes one joint (two nerves), and the codes were billed per-nerve prior to 2012. There may be physicians who are still using the code on a per-nerve and not a per-joint basis. As such, they developed a *CPT Assistant* article (publication date: February 2015) stressing that each of these codes now includes the entire joint (i.e. two nerves) and not just one nerve, as before. Also, the specialty societies will perform additional education through their publications on this topic.

The Workgroup discussed this issue and agreed that the CPT Assistant article is a good proactive step. **The Workgroup recommended that the specialty societies submit revised introductory language to the CPT Editorial Panel immediately for CPT 2016 to address any inappropriate coding regarding reporting per nerve instead of per joint issue. The Workgroup requested that AMA staff compile data on how many times a service is reported on the same patient on the same day and 2014 preliminary Medicare utilization. The Workgroup will review the additional data and again review this issue in April 2015.**

**Action Plan Review (CPT codes 69210 & 76940)**

**69210 Removal impacted cerumen requiring instrumentation, unilateral**

The Workgroup reviewed the action plan for code 69210 the specialty societies requested that this service go to CPT for creation of another code to describe complex removal of cerumen. **The Workgroup agrees with the specialty societies that a new code be created to report complex removal of cerumen and that CPT code 69210 be removed from the MPC list.**

**76940 Ultrasound guidance for, and monitoring of, parenchymal tissue ablation**

The Workgroup reviewed the action plan for 76940 and disagreed that a CPT Assistant article will address the inappropriate reporting of this low volume code. **The Workgroup agrees with the specialty societies that the code is not overvalued. The Workgroup recommends that the RUC flag CPT code 76940 as not to be used for validation of physician work**

**and for the specialty societies to submit a CCI edit indicating that 76940 should not be reported with the 30000 series ablation codes.**

**The RUC approved the Relativity Assessment Report.**

**XVII. Research Subcommittee (Tab 30)**

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

- **The RUC reviewed and accepted the October 2014 Research Subcommittee Review report.**
- **Research Subcommittee Guidelines and Requirements Document**

In follow up to previous Subcommittee discussion, Doctor Collins and AMA staff drafted a Research guidelines and requirements document for the Subcommittee's review and consideration at the January 2015 meeting in an effort to centralize Research Subcommittee rules and requirements. The review requirements included in the initial draft were consistent with the Subcommittee's current rules. The research request submission requirements were somewhat strengthened in an attempt to better facilitate the subcommittee's review of specialty society requests.

The Research Subcommittee had a robust discussion regarding the document and agreed that the overall document was appropriate. The Subcommittee noted that having a concise, centralized document will help to improve and streamline its review processes.

The Subcommittee agreed that three portions of the document should be further strengthened, suggesting the following changes to the initial draft. The Subcommittee approved the following content modifications to the initial draft:

- Revise the review requirements for clinical vignettes so that if there is no existing vignette in the RUC database, then Research vignette review is required.
- Change the Survey sample language so it is explicitly stated that societies should describe the population used in their survey sample.
- Change the survey instrument review requirements so that Research review and submission of summary data is required, if an advisory committee desires to add a new question to the survey.

There was Subcommittee discussion regarding whether this new document would make future research review and approval of targeted survey sample requests unnecessary. Several Subcommittee members expressed their reservation with discontinuing the requirement for explicit research approval of targeted survey samples and the Subcommittee collectively decided to not change this review requirement.

The final document is separately included with the final Research Subcommittee report for January 2015.

**The Research Subcommittee recommended the adoption of the *Research Subcommittee Guidelines and Requirements* document, as written in Appendix A of the final Research Subcommittee report.**

The Subcommittee requested for AMA staff to draft an appendix with definitions of terms used in the document (ie “targeted”, “sample”, etc.) for the Subcommittee’s review at its April 2015 meeting. The Subcommittee also requested for AMA staff to conduct analyses of the Subcommittee’s past review and approval of targeted survey sample requests (ie frequency, approval rate, etc.) Finally, the Subcommittee also asked AMA staff to track specialty feedback regarding the new rules document and provide that collated feedback at an upcoming Subcommittee meeting.

- **Introductory Text for Online RUC Survey Instrument**

At the September 2014 Research Subcommittee meeting, a specialty society staffer expressed their concern that the survey instrument starts abruptly with no introductory paragraph to explain the purpose of the survey instrument. The Subcommittee agreed that the lack of an introductory paragraph in the survey instrument was a concern and requested for AMA staff to draft a paragraph for the Subcommittee to review at the January 2015 meeting.

**The Subcommittee reviewed the draft text and approved the text for inclusion in the RUC Online Survey tool as follows** (note, the below text includes minor editorial changes Submitted by a Subcommittee member to the Subcommittee after the in-person meeting):

*You have been selected to participate in an AMA/Specialty Society RVS Update Committee (RUC) survey. As you may know, the components of the Medicare physician payment schedule are physician work, practice expense and professional liability insurance. This survey will help our society, in concert with the RUC, recommend accurate relative values for physician work to the Centers for Medicare and Medicaid Services. Each survey is comprised of questions relating to the physician work for one or more physician services.*

- **Other Business**

**RUC Survey – Transition to the Online RUC Survey Tool (*Informational Only*)  
Overview of Updates to RUC Online Survey Tool and Process**

The Chair noted that an updated online survey timeline as well as an overview of updates to the online tool are provided in the agenda packet. It was noted that AMA staff are continuing to solicit feedback from specialty society staff utilizing Qualtrics. The feedback has resulted in editorial design/content improvements. The Research Subcommittee will be asked to review only significant staff suggestions at a future RUC meeting. The Chair stated that the survey is currently being used by two-thirds of surveying societies at each meeting, though there is no set date for when the tool will be mandatory for all societies to use. All specialties are strongly encouraged to use the Qualtrics survey tool for all future surveys.

**Intensity and Complexity Ratings**

Several Subcommittee members shared their confusion with how to interpret the new Intensity and Complexity measures. Other’s stated their thoughts that as the RUC had been using the old intensity and complexity rating scale for so long, that hopefully it would just take a little time for all RUC members to get a full grasp of the new rating scale.

The Chair explained that for the new intensity and complexity rating scale, the survey respondents are rating the survey code relative to the key reference code that they selected.

**The Chair requested for AMA staff to include explanatory text with examples in all future email communications to RUC members and RUC alternates during the initial RUC review period prior to each RUC meeting. The Chair also stated that the Summary of Recommendation form for the April 2015 meeting will be updated to include a small legend with the new rating scale.**

**The RUC approved the Research Subcommittee Report**

## **XVIII. RUC Strategy Session on Surgical Global Periods (Tab 31)**

Doctor Levy began the Global Period Strategic Session by updating the RUC on a recent visit that she, Doctor Peter Hollmann, Jay Ahlman and Sherry Smith took to CMS. On December 12, 2014, they met with Sean Cavanaugh, CMS Deputy Administrator & Director, and other CMS staff in Washington, DC. This meeting acted as an opportunity to sit down with CMS staff and explain the RUC and CPT's real concerns over the agency's decision to move forward with transitioning away from surgical global periods.

Next, the Chair explained that one of the key premises behind this proposal is the perceived notion that the amount of post-operative visits bundled into surgical globals is overstated. CMS has relied on three HHS Inspector General Reports (ophthalmology, orthopaedic and cardiovascular services) to form the basis of suspicion that the post-operative visits included in the surgical globals are inaccurate. However, this premise relies on almost a decade old data. Since publication, one-third of the codes identified in the reports have been reviewed by the RUC in the misvalued code project. Of those codes reviewed by the RUC, 46% received reduced post-operative visit recommendations.

The RUC has consistently maintained that the core purpose of the Committee's work is to improve the accuracy of payment for physician services within the RBRVS. Thus, the RUC agrees with the CMS concern that payment for surgical bundles should represent the actual resources to perform the service. However, one of the key concerns of this transition is the large disruption that will occur in not only physician payment but also beneficiary payment (e.g. co-pays). Therefore, there appear to be a number of other ways to address the agency's concerns regarding payment accuracy. The following is a list of several alternatives discussed by the RUC:

- *RUC review of outlier visits* – A screen of this nature has already been created identifying dozens of both 010- and 090-day global period codes without outlier visits.
- *Data collection of CPT code 99024* – There are several large physician groups (e.g. Mayo Clinic and Geisinger) that already mandate the use of 99024 with all post-operative E/M services.
- *Pilot test the transition of codes CMS considers of high concern.*
- *Medicare length of stay data to assess hospital visits*
- *Required reporting of post-op visits via no-pay claims*

Finally, Doctor Levy made it clear that although some stakeholders are already working to address the new policy via legislation, the RUC needs to proceed with the creation of an implementation strategy to ensure maximum influence with CMS. The RUC has a real opportunity until March to affect the agency's future rulemaking in the 2016 NPRM. A letter and

report detailing the RUC's discussion during this strategic session will be delivered to CMS by March, in time to be considered for the upcoming NPRM.

## **I. Scope of Review**

Doctor Levy and AMA Staff provided extensive background and summary data to provide the RUC and other stakeholders with a more complete picture of the scope of the undertaking to convert all 010-day and 090-day surgical global services to 000-day services. There are 4,267 services on the Medicare Physician Payment Schedule with a 010-day or 090-day global period (473 010-day services and 3,794 090-day services). Of these services, 1,156, or 27 percent, had 2013 Medicare utilization over 1,000 and only 267 services, or 6%, had utilization over 10,000. It was also noted that these services account for 10.5% of all allowed charges in the Medicare Physician Payment Schedule.

It was also noted that only 9% of all 010-day global codes have more than one post-operative office visit and 85% of all established patient office visits in 010-day surgical packages are a relatively low level office visit, 99212. In addition, only 4% of all 090-day global codes have more than 5 post-operative office visits and 98% of all established patient office visits in 090-day surgical packages are a 99213 or lower.

Doctor Levy and AMA staff also provided stakeholders with data analyses showing the varying impact of the proposal on each specialty in regards to estimating the number of potential codes for review by each specialty, and the aggregate allowed charges and Medicare utilization for each service by specialty.

*There are three attachments in the addendum that further enhance the specialty impact of this proposal.*

- **Appendix A** – Specialty Impact Analysis – Estimated Number of Survey Codes
- **Appendix B** – Specialty Impact Analysis by Global Period – General View
- **Appendix C** - 010-Day and 090-Day Global Services Utilization and Allowed Charges by Specialty (This is a dynamic Excel table. Only available in electronic files.)

## **II. Timetable**

In the 2015 Final Rule, CMS finalized their proposal to have the entire set of 473 CPT codes with 010-day global periods reviewed by the CPT 2017 review cycle and the entire set of 3,794 CPT codes with 090-day global periods reviewed by the CPT 2018 review cycle. Under this assumption, the RUC would have six meetings to complete these recommendations.

The RUC communicated three primary concerns with the agency's stated timeline.

1. Even if one assumes that only those codes with greater than 1,000 Medicare frequency would need surveys, there are still 268 codes with a 010-day global and 888 codes with a 090-day global that meet that criterion. Just these codes alone would require more than six meetings to adequately review.
2. There is no solution to systematically, accurately and efficiently, transition codes from 010-day and 090-day global periods to 000-day global periods. Simply using a reverse building block methodology to systematically convert all 010-day and 090-day global codes to 000-day global codes by backing out the bundled E/M services would be highly inappropriate, due to the fact that magnitude estimation was used to assemble the work RVUs for surgical codes.

3. Most importantly, in order for the RUC to review the 090-day global codes, adequate comparator codes must be available. Therefore, CMS would need to finalize the work RVUs for the 010-day global codes prior to the RUC beginning the review process on the 090-day global codes. According to the new CMS timeline, final work RVUs for codes reviewed in the CPT 2017 cycle will be published in the November 2016 Final Rule.

**The RUC unanimously agreed that the current timeline of having all 010-day global period codes reviewed by CPT 2017 and all the 090-day global codes reviewed by CPT 2018 is unattainable in a resource-based, fair and accurate manner.**

The RUC members at the table did communicate that in order to have an appropriate amount of time for review of surgical services, they were willing to have additional meetings in the future to address individual codes, like previous Five-Year Review meetings. In addition, some members mentioned that extending the RUC meeting until Sunday, as was typical in the past, would be an economical means to review additional codes. Finally, the RUC members did indicate their willingness to potentially attend a summer RUC-only fly-in meeting to respond to the NPRM and build consensus prior to the RUC's response in the comment period.

### III. Prioritization

The RUC discussed a list of criteria that could help prioritize which services would need to be reviewed first. Decisions on the prioritization for the global period transition will have a major impact to many RUC stakeholders. The following were discussed:

#### Issues to consider:

1. **Medicare Spending and Frequency:** The top 10 010-day global codes account for 50% of Medicare allowed charges for 010-day global services and the top 10 090-day global codes account for 1/3 of Medicare allowed charges for 090-day global services. This is important to note as hundreds or even thousands of services are low volume and have very little impact on overall Medicare spending. **(See Appendix D for further data.)**
2. **Specialty Workload:** The top 15 specialties make up 90% of allowed charges for both 010-day and 090-day services. Also, certain specialties have a disproportionate number of 010-day and/or 090-day services to review. **(See Appendix D for further data.)**
3. **Should all 010-day codes be reviewed prior to any 090-day codes?:** Under the current CMS timeline, the conversion of all 010-day services is scheduled for one year prior to all 090-day services. The lack of reference codes with high enough intensity for certain 010-day and 090-day services will be a challenge. **(See Appendix E for further data.)**

#### Criteria to consider:

1. **MPC List (Number of codes: 000=45; 010=31; 090=49):** The intensity of 000-day global services is generally much less than 010-day and 090-day services. Furthermore, some surgical specialties do not perform many 000-day global services and would have great difficulty finding reference codes in order to survey.
2. **Intra-service time:** There are currently very few 000-day global services with intra-service time greater than 60 minutes. One possible method to partially address this issue could be to start with reviewing codes with relatively shorter intra-service times, in order to create additional reference codes for other codes.

**The RUC recommends that the multi-specialty points of comparison (MPC) codes and their related family codes (as defined by the specialty) should be reviewed first to serve as initial anchors. The RUC also believes that the Moderate sedation codes could be reviewed as issues related to moderate sedation should be reviewed simultaneously.** The RUC agreed that converting the 31 010-day surgical global period MPC codes would be a beneficial starting point, as these codes would definitely have value as comparators. Following this, the 49 090-day global period MPC codes could be reviewed. Furthermore, the RUC noted that a joint CPT/RUC workgroup on moderate sedation is already prioritizing the review of codes in Appendix G (moderate sedation) to disaggregate the work associated with moderate sedation, as it will now be separately reportable. There are currently 28 010-day and 37 090-day global codes that will be scheduled for review shortly.

#### IV. Methodology

##### Reverse Building-block

The RUC discussed concerns expressed by many stakeholders that the usage of the reverse-building block methodology as the sole unbundling method could be tempting to CMS solely due to its relative ease of implementation. The RUC noted that if a reverse building block technique were applied to all 010-day and 090-day global services, nearly half of minor and major surgical procedures would be reduced to a work value reflecting a low intensity.

**The RUC unanimously agreed that unbundling the post-operative visits via “reverse building block” or other formulaic approaches would be highly inappropriate and cannot be acceptable as the primary method to value surgical services.**

It was noted that the current RUC 000-day survey instrument template is insufficiently equipped for capturing all necessary data to review facility-based and major surgical procedures, including a lack of site of service, general length of stay and same-day E/M questions. The RUC agreed that the **Research Subcommittee should review the 000-day surgical survey instrument at the April 2015 RUC meeting and recommend how to best modify the existing survey instrument and/or create a new survey instrument to be able to handle facility-based surgical procedures.**

##### Alternative Methodologies

It was noted that there are over 3,000 010-day and 090-day codes which were performed less than 1,000 times in Medicare for 2013.

	<i>2013 Medicare Volume</i>		
Global	999-501	500-101	100-0*
010	52	78	75
090	373	998	1,535

\* (inc. new codes since 2013 and non-Medicare codes)

Many of these codes will require alternate methodologies for validation, as they may be performed too infrequently to collect representative survey data. It was mentioned that the Research Subcommittee has only approved a mini-survey to fill in gaps for low volume services within a larger family of services. Thus, one, or several, higher volume codes would be fully surveyed, while the low volume family codes would receive only partial surveys.

Another alternate methodology that was suggested as possibly being appropriate is the use of RUC approved extant databases (e.g. STS database). Several RUC members, and staff, noted that there may be other existing extant databases (e.g. EMR systems, registries, etc.) that the RUC and CMS could use for validation. For instance, one RUC member put staff in contact with a representative from the

Mayo Clinic about the possibility of obtaining data relating to the use of CPT code 99024 *post-op follow-up visit*. In follow-up to this discussion, a CMS representative mentioned that they are looking for specific information regarding the actual databases available and contact information that the agency could use to follow-up.

**Therefore, the RUC recommended that AMA staff reach out to RUC participants to collate any points of contacts, EMR systems, registries or any other databases that may be of potential use in validating post-operative visits for surgical services.**

## **V. Practice Expense and Professional Liability Insurance Issues**

The RUC reviewed several issues and examples of the effects the transition will have on payment for practice expense and professional liability insurance.

### Practice Expense

One of CMS' criticisms of the current surgical global period system is that there is a different mix of post-operative direct practice expense (PE) inputs for global period Evaluation and Management (E/M) services and separately-reported E/M services. The RUC reaffirmed that there are in fact many appropriate differences between these two E/M services.

For instance, certain surgical E/M services include additional clinical staff time relative to the clinical staff time for separately-reported E/M visits. Examples include the additional clinical labor time required to care for stomas or for the setup and cleaning of scope equipment required at a post-operative visit.

- 6% of facility-only 010-day and 090-day codes (197 of 3,329) have clinical staff post-service time greater than the post-operative visit total time.

In addition, the vast majority of facility-only 010-day and 090-day surgical global codes have direct practice expense supplies and/or equipment inputs that are distinct from established patient office visits (**See Appendix F and Appendix G for a list of distinct direct PE Supplies and Equipment**).

- 95% of facility-only 010-day and 090-day codes (3,167 of 3,329) have supplies distinct from the standard E/M PE packages.
- 75% of facility-only 010-day and 090-day codes (2,489 of 3,329) have equipment distinct from the standard E/M PE packages.

**The RUC agreed that there are numerous individual services currently bundled into the surgical service global period that will now need distinct CPT codes following the transition to 000-day globals. Therefore, the RUC recommends the formation of a joint CPT/RUC workgroup to discuss what would be needed in terms of new codes.**

The RUC also discussed that not just direct practice expense inputs will be affected. Changes to the inputs that calculate indirect PE will also need to be considered. Indirect practice expense payment is derived from the weighted average of the specialty mix that performs each service (**See Appendix H for PE Expense per Hour by Specialty**). Currently, the indirect PE related to the post-operative work for surgical services is correctly derived from the costs associated with the surgical specialties performing the service. Under the proposal, this identical post-operative work would be inappropriately diluted due to the broad mix of specialties that perform separately reported E/M services.



The RUC discussed that this issue is difficult to model, since only CMS has certain inputs necessary to fully calculate the indirect PE RVU for individual CPT codes. **Therefore, in an effort to be completely transparent, CMS needs to model the indirect practice expense impacts under the transition. Stakeholders need the proper tools and advance warning to fully assess the impacts resulting from these changes.**

#### Professional Liability Insurance

Another consequence of the CMS decision is the large redistribution of Physician Liability Insurance (PLI) payment away from the primary providers of surgical procedures and into a more diverse group of providers. The PLI RVU for each service is calculated by multiplying the work RVU by the specialty risk factor of the specialty(ies) who perform the service (**See Appendix I for CY2015 PLI Risk Factors**). Currently, the work RVUs of the proxy E/M services contained in the global period for 010- and 090-day surgical codes are part of the PLI calculation. This valuation is appropriate because the liability costs of a specific service should be derived from those of the performing specialties. However, under the CMS proposal, the liability costs associated with the post-operative work would be removed from the primary service and would be artificially diluted by the wide mix of specialties performing E/M services.

Below is one example of this shift:

CPT code 33534 *Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts*

Current Surgical Global (090-day global):

Work RVU= 39.88

Post-op Visits: 1- 99212, 1- 99214, 1- 99231, 1- 99232, 3- 99233, 1- 99238, 1- 99291

CPT Code	Work RVU	Specialty weighted PLI RVU	Final PLI RVU (2015)
33534	39.88	6.67	<b>8.99*</b>

*\*Note that this final PLI RVU has gone through budget neutrality calculations prior to publication.*

Note that the entire work RVU (39.88) is calculated by the specialty weighted PLI RVUs directly associated with top providers of the service (Cardiothoracic surgeons).

CMS Elimination of Surgical Global (000-day global):

Intra-operative work RVU= 23.97

Post-operative E/M work RVU= 15.91

CPT Code	Work RVU	Specialty weighted PLI RVU	Final PLI RVU
33534	23.97	6.67	<b>5.40* (estimated)</b>
Post-operative work (paid separately)			
99212 (x1)	0.48	1.42	0.04
99214 (x1)	1.50	1.22	0.10
99231 (x1)	0.76	1.40	0.05
99232 (x1)	1.39	1.55	0.09
99233 (x3)	6.00	1.61	0.42
99238 (x1)	1.28	1.56	0.09
99291 (x1)	4.50	2.07	0.40
<b>Total E/M Post-operative PLI RVU</b>			<b>1.19</b>
<b>Total PLI RVUs for 33534 (090-day global)</b>			<b>8.99</b>
<b>Total PLI RVUs for 33534 (000-day global)</b>			<b>6.59 (5.40 + 1.19)</b>
<b>Percent Difference from move to 000-day global</b>			<b>-27%</b>

Moving to a 000-day global period will result in a 27% reduction in PLI RVUs for CPT code 33534.

**The RUC agreed that a new PLI methodology that is resource-based and attributes costs fairly will need to be created prior to the elimination of surgical globals.**

## **VI. CPT Definition and New Codes**

In addition to the post-operative E/M visits, there are many other post-operative care services currently bundled in surgical globals. Following the unbundling of post-operative care, many of these services would need to be separately reported using new or existing CPT/HCPCS codes. The CPT 2017 deadline date for submission is now July 8, 2015. All stakeholders will need to move quickly in order to articulate all needed codes in the first half of 2015.

The Medicare Claims Processing Manual (Chapter 12, Section 40.1) provides several examples of services, in addition to the post-op visits, which are currently bundled into the global surgical package:

- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room
- Post-surgical pain management by the surgeon
- Supplies, except for those identified as exclusions
- Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Separately, the RUC also noted that the CPT Surgical Package Definition (**See Appendix J for the full definition**) would also need to be reviewed in detail as, in addition to typical postoperative follow-up care, several other services are also bundled into the CPT Surgical package:

- Evaluation and Management (E/M) service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical)
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians or other qualified health care professionals
- Writing orders
- Evaluating the patient in the postanesthesia recovery area

**The RUC reviewed these lists and reiterated their position, as agreed upon during the PE discussion, that a joint CPT/RUC workgroup should be created to identify CPT codes to separately report these physician services.**

## **VII. Other Issues**

### Multiple Surgery Payment Reduction Policy

The RUC and other stakeholders discussed CMS payment reduction policies that impact the 010-day and 090-day global procedures, including the multiple surgeries reduction, bilateral payment reduction, co-surgeons and team surgeon payment reductions and the assistant-at-surgery reduction, and noted that many of these reductions are largely based on and justified by the redundancy of bundled post-operative E/M visits between multiple services or when multiple surgeons are performing the same surgery.

The RUC agreed that CMS payment reduction policies that impact 010-day and 090-day global codes should be analyzed by CMS in detail and the reduction percentages should be appropriately reduced.

The RUC discussed a [CMS-commissioned study by Harvard researchers](#) in 1993 to analyze the physician work and time involved for multiple procedures. At the time, CMS used this study to justify changes to the Multiple Surgical Payment Reduction. One stakeholder emphasized the following findings by the Harvard researchers, which included:

“We found economies of scope in performing multiple procedures. For two service multiples, the marginal intra- service work and time of the second procedure is about 75 percent of that required to perform that procedure alone. For pre- and post-service work, this amount was 20 percent, suggesting significantly greater economies. We found economies of scope for total work to be, on average, 48 percent.”

**The RUC agreed to form a workgroup to evaluate the multiple surgery payment reduction and determine how the payment reduction should be modified in the event of unbundling of the surgical globals.**

#### Potential Change in Level of Post-operative Visits

The RUC noted that, on average, the global surgical packages have much lower levels of office and hospital visits relative to separately-reported E/M visits. The median established office visit in a global surgical package is a 99212, whereas the median level for separately-reported visits is a 99213. Only 1% of all established patient office visits in 010-day and 090-day global surgery packages have a visit level above a 99213, whereas 43% of all separately-reported E/M visits are reported as a 99214 or 99215. The median hospital visit in a global surgical package is a 99231, whereas the median level for separately-reported hospital visit is a 99232. 57% of hospital visits in a global package have a hospital visit level of 99231, whereas only 12% of all separately-reported hospital visits are reported as a 99231. (See *Appendix K* for the complete analysis)

Given the vast majority of 010-day and 090-day global codes have post-operative visits that are typically coded at relatively lower levels, CMS should anticipate an upward shift in the level of post-operative E/M reporting that would likely occur if post-operative visits are unbundled.

#### Impact of Moderate Sedation Unbundling

The RUC acknowledged that there are 28 010-day and 37 090-day global codes in Appendix G. With the pending removal of physician time/work of moderate sedation from current 000-day Appendix G codes, these codes may not be available to use for reference services lists until CMS finalizes moderate sedation unbundling. This is another challenge that will impact the global period transition.

**The RUC adjourned at 6:00pm.**

Members Present: Scott Manaker, MD, PhD, FCCP (Chair), Guy Orangio, MD (Vice 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, Margaret Neal, MD, Tye Ouzounian, MD, Chad Rubin, MD, John Seibel, MD, W Bryan Sims, DNP, APRN-BC, FNP, Robert Stomel, DO, Thomas J. Weida, MD

## **I. Medical Supplies and Equipment Pricing**

At the September 2014 RUC meeting, the Practice Expense (PE) Subcommittee discussed a staff note that detailed the history of CMS' work with contractors as well as their proposal to use the GSA Medical Supply Schedule/VA Federal Supply Schedule to update pricing for high cost supplies and equipment. The PE Subcommittee was also scheduled to discuss the possibility of extending PE criteria to RAW screens. The Subcommittee quickly combined the two issues to determine if medical supplies and equipment pricing could be addressed by a relativity screen. Much like the current screens that the RAW conducts, a PE screen could identify any errors in relativity that has caused services to be over- or under-valued. The PE Subcommittee ultimately decided that it was premature to develop a practice expense screen and that they wanted to be careful not to incentivize using outdated devices or create a situation where the RUC is stifling the development of new technology. The Subcommittee determined that it would be more appropriate to start by reviewing data that will illuminate how high cost supplies and equipment impact the overall distribution of PE relative value units (RVUs) across the physician payment schedule.

For the January 2015 RUC meeting, RUC staff queried the RUC database to provide data for the top quartile of codes based on the non-facility PE RVU as a percentage of the total RVU. The result is the 276 codes (included in agenda tab 26). In addition to the non-facility PE RVU as a percentage of the total RVU percentage, the attached spreadsheet displays the following:

- Any supplies costing more than \$500
- Any equipment costing over \$1 million
- Total utilization
- Most recent PE Subcommittee review date
- PE RVU multiplied by the utilization of the code

When reviewing this data it is important to keep in mind that there is not a direct correlation between the pricing of direct PE inputs and the PE RVU as the formula that CMS uses in their bottom-up methodology to derive the PE RVU also factors in the physician work RVU and the indirect practice expense, which varies based on the specialties that perform the service.

In reviewing the data, the PE Subcommittee observed that they (and the full RUC) have already recently reviewed most of the high impact (PE RVU multiplied by utilization) codes in recent years. PE Subcommittee members observed a high incidence of low work RVU codes in the top quartile, demonstrating that the service does not adversely affect other services in the RBRVS since the relatively small work RVU neutralizes the impact of the high cost practice expense inputs.

After some discussion the PE Subcommittee determined that they may revisit this issue in the future and refine the analysis to account for the issues outlined above. At this time the PE Subcommittee is confident that it has done its due diligence in reviewing and making the appropriate adjustments to high impact services through its current process. The PE Subcommittee determined that no further action on this issue is needed at this time.

## **II. Penile Trauma Repair (5443X1 and 5443X2) – Pre-Service Time Standards for Emergent 90 Day Global Services**

During discussion of the direct practice expense inputs for these services, the PE Subcommittee considered reducing the pre-service time from 60 minutes to 15 minutes based on a direct crosswalk to CPT code 44950 *Appendectomy*, which is clearly an emergent service based on the description of the typical patient in the vignette. The PE Subcommittee noted that CPT code 44960 *Appendectomy; for ruptured appendix with abscess or generalized peritonitis* also has 15 minutes of pre-service time. The PE Subcommittee discussed that there was some precedent for reducing the amount of pre-service time from the 60 minutes that is standard for most 90 day global services for emergency surgery. The Chair and AMA staff looked at a number of services that were cited as being emergent and it was not clear that the PE Subcommittee has been consistent in reducing pre-service time in these instances and the code descriptors and vignettes did not identify the services as definitively emergent. The PE Subcommittee decided to approve the specialty society's recommendation for 60 minutes of pre-service time in the facility setting for both services. However, the PE Subcommittee is concerned about the pre-service time for emergency 90 day globals since it is unlikely that clinical staff would have the opportunity to perform their pre-service activities for these services. **In order to discuss the issue and determine next steps, the PE Subcommittee requests that AMA staff research pre-service time for emergency 90 day global services and prepare a report for the PE Subcommittee's review at the April 2015 PE Subcommittee meeting.**

**III. Practice Expense Recommendations for CPT 2016 and CMS Request/Relativity Assessment Identified Codes**

Tab	Title	PE Input Changes
5	Endobronchial Ultrasound – EBUS	Major Revisions
6	Transcatheter Pulmonary Valve Implantation	Minor Revisions
7	Intravascular Ultrasound	Minor Revisions
8	Mediastinoscopy with Biopsy	No Revisions
9	Genitourinary Catheter Procedures	Major Revisions
10	Penile Trauma Repair	No Revisions Standard 090 Day Global
11	Intrastomal Corneal Ring Implantation	Major Revisions
13	Cerumen Removal – PE Only	Minor Revisions
14	Radiologic Exam – Spine	Minor Revisions
16	Surface Radionuclide High Dose Radiation Brachytherapy	Minor Revisions
17	Immunofluorescent Studies	Minor Revisions
18	Vestibular Caloric Irrigation	No Revisions
19	Bone Biopsy Excisional	No Revisions
23	Dilation and Probing of Lacrimal Nasolacrimal Duct	Major Revisions
25	Echo Guidance for Ova Aspiration	Minor Revisions

**AMA/Specialty Society RVS Update Committee  
Administrative Subcommittee Report  
January 29, 2015**

**Tab 27**

Members: Doctors Michael Bishop (Chair), Margaret Neal (Vice Chair), Margie Andreae, Dale Blasier, Ronald Burd, Anthony Hamm, DC, J. Leonard Lichtenfeld, William Mangold, Jr., David Regan, Joseph Schlecht and James Waldorf.

**I. Financial Disclosure – Clinical Trial Involvement**

The Administrative Subcommittee reviewed the Financial Disclosure statement and discussed adding a sentence to identify presenters who participated in clinical trials that involve the codes under review. The Administrative Subcommittee determined it is necessary to have physicians involved in clinical trials for the services being reviewed by the RUC, which they have received material income be identified as part of the current financial disclosure statement. **The Administrative Subcommittee recommends the financial disclosure statement be revised to the following:**

**AMA/Specialty Society RVS Update Committee (RUC)  
Financial Disclosure Statement For  
Specialty Society Presenters**

I certify that my personal or my family members'\* direct financial interest in, and my personal or my family members' affiliation with or involvement in any organization or entity with a direct financial interest in the development of relative value recommendations in which I am participating are noted below. Otherwise, my signature indicates I have no such direct financial interest or affiliation with an organization with a direct financial interest, other than providing these services in the course of patient care.

For purposes of this disclosure "direct financial interest" means:

- A financial ownership interest in an organization\*\* of 5% or more; or
- A financial ownership interest in an organization\*\* which contributes materially\*\*\* to your income; or
- Ownership of stock options in an organization\*\*; or
- A position as proprietor, director, managing partner, or key employee in an organization\*\*; or
- Serve as a consultant, researcher, expert witness (excluding professional liability testimony), speaker or writer for an organization\*\* **or participate in a clinical trial that involves the services being reviewed**, where payment contributes materially\*\*\* to your income.

*\*Family member means spouse, domestic partner, parent, child, brother or sister. Disclosure of family member's interest applies to the extent known by the representative or presenter..*

*\*\* Organization means any entity that makes or distributes the product that is utilized in performing the service, and not the physician group or facility in which you work or perform the service.*

*\*\*\*Materially means \$10,000 or more in income (excluding any reimbursement for expenses) for the past twenty-four months.*

**Include only interests that relate to the specific issue that you are presenting at this RUC meeting.**

Specific Disclosure (i.e., list organization)	Explain relationship between the service(s) that you are presenting and your disclosure	Identify interest for the past 24 months (circle one)	Identify cumulative lifetime interest (circle one)	If disclosure relates to stock, please list number of shares owned, options or warrants
		N/A < \$10,000 ≥ \$10,000	< \$10,000 ≥ \$10,000	

*Approved by the RUC – January 31, 2015*

## **II. Disclosures from RUC Participants/Audience**

In September 2014, the RUC requested that the Administrative Subcommittee consider conflicts for individuals that speak to issues from the audience at RUC meetings. The Subcommittee noted that currently when participants from the audience speak at the microphone, they introduce themselves and announce any conflicts of interest/financial interests in the codes being reviewed before they make a statement. The Subcommittee discussed that participants who intend to speak at the microphone should be aware of what the RUC constitutes as a conflict of interest or financial interest prior to speaking at a RUC meeting. **The Administrative Subcommittee recommends identifying the financial disclosure policy on the confidentiality statement the participants sign at the registration desk. AMA staff will draft a revised confidentiality statement for review at the April 2015 meeting.**



**Members:** William Mangold, MD (Chair), Anthony Hamm, DC (Co-Chair), Jane White, PhD, RD, FADA (Alt. Co-Chair), Scott Collins, MD, Charles Fitzpatrick, OD, Mary Foto, OTR, James Georgoulakis, PhD, Emily Hill, PA-C, Eileen Moynihan, MD, Dee Adams Nikjeh, PhD, CCC-SLP, Paul Pessis, AuD, Rick Rausch, PT, W Bryan Sims, DNP, Timothy Tillo, DPM and Doris Tomer, LCSW

### **I. Introduction and CMS Update**

The meeting was called to order at 1:10 PM. Doctor Hamm asked HCPAC members to introduce themselves.

Doctor Edith Hambrick from CMS attended the HCPAC meeting and gave the HCPAC an update on recent personnel changes at the Agency. She noted that Marilyn Tavenner is stepping down as CMS Administrator at the end of February. Andrew Slavitt will take over as Acting Administrator. Kathy Bryant current Director of Practitioner Services will be moving on within the Agency and John McInnis, MD will assume her role. Chris Ritter-Smith will be wearing two hats for the time being as Deputy Director, Hospital and Ambulatory Policy Group and Director of Outpatient Services.

In response to a question from the group, Doctor Hambrick reported that the Agency has been reviewing comment letters regarding the transition of 10 and 90 day global codes to 0 day codes. She did note that the Agency welcomes any additional comments on this issue and is willing to take meetings with stakeholders. However, these meetings and any comments are now outside of the 60 day Final Rule comment period which ended January 6<sup>th</sup>.

### **II. CMS Request/Relativity Assessment Identified Codes**

Excision of Nail Bed (CPT Code 11752)  
*American Podiatric Medical Association*

Tim Tillo, DPM, representing the APMA, stated that code 11752 was tabled at the request of APMA at the September 2014 RUC meeting. At the time, the plan was for APMA to discuss with other specialties that perform this service, whether code 11752 should be deleted or some other CPT action or RUC survey with all groups.

In the meantime, the APMA has worked with the Orthopedic and Hand Surgeons to determine the appropriate next steps and all the groups have decided that the best course of action is to submit a CCP to the CPT Editorial Panel. Staff reminded the specialty that the CCP must be submitted by the July 2015 deadline. The HCPAC accepted the specialty recommendation.

### **III. New Business**

Doctor Hamm announced that Paul Pessis is the new Audiology representative to HCPAC. Doctor Hamm then announced that this was Doctor Mangold's last meeting and asked that the HCPAC members to join him in honoring his service as Chair.

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

**I. Joint CPT/RUC Workgroup on Codes Reported Together Frequently – Progress Report**

Kenneth Brin, MD, Chair of the Joint Workgroup provided a summary of the Workgroup's review of the fourth iteration of the bundled services project. Seven groups of services have been identified. The Joint Workgroup recommended and the Relativity Assessment Workgroup agreed that for three groups coding proposals for the 2017 CPT cycle should be submitted; one group is not appropriate to bundle; one groups action plan will be further reviewed at the next Joint Workgroup meeting; and two groups will be reviewed again after utilization data is available once current coding changes take effect.

**II. New Technology/New Services Review (37 codes/21 code families)**

The Workgroup reviewed 37 codes or 21 families of services of services that were flagged as new technology. **The Workgroup recommends:**

CPT Code	Workgroup Recommendation
29914	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
29915	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
29916	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
31295	Due to rapid growth in service volume, review after 2 more years of Medicare utilization data (2014 and 2015 data), October 2016.
31296	Due to rapid growth in service volume, review after 2 more years of Medicare utilization data (2014 and 2015 data), October 2016.
31297	Due to rapid growth in service volume, review after 2 more years of Medicare utilization data (2014 and 2015 data), October 2016.
31634	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33620	Develop CPT Assistant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.
33621	Develop CPT Assistant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.
33622	Develop CPT Assistant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.
38900	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
49327	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
49412	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
53860	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
55706	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
55866	Survey for April 2015. Specialty society should consider surveying 55845 and 55866 at the same time.
64566	Survey for April 2015.
64569	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
64570	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
65778	Survey for April 2015.
65779	Survey for April 2015.
66174	Survey for April 2015.
66175	Survey for April 2015.
76881	Develop CPT Assistant Article to define the proper coding of extremity ultrasound, particularly as it applies to the elements necessary to report a complete study. Review in October 2016 after 2 years of additional Medicare utilization data.

*Approved by the RUC – January 31, 2015*

76882	Develop CPT Assistant Article to define the proper coding of extremity ultrasound, particularly as it applies to the elements necessary to bill a complete study. Review in October 2016 after 2 years of additional Medicare utilization data.
88363	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
91117	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
92132	Review at RAW in April 2015. Specialty society should explain what is driving the utilization and whether other measures may be needed, such as CPT Assistant article..
92133	Remove from list, no demonstrated technology diffusion that impacts work or practice expense
92134	Remove from list, no demonstrated technology diffusion that impacts work or practice expense
92228	Remove from list, no demonstrated technology diffusion that impacts work or practice expense
93462	Remove from list, no demonstrated technology diffusion that impacts work or practice expense
93463	Remove from list, no demonstrated technology diffusion that impacts work or practice expense
93464	Remove from list, no demonstrated technology diffusion that impacts work or practice expense
95800	Due to rapid growth in service volume, review after 2 more years of Medicare utilization data (2014 and 2015 data), October 2016.
95801	Due to rapid growth in service volume, review after 2 more years of Medicare utilization data (2014 and 2015 data), October 2016.
95806	Due to rapid growth in service volume, review after 2 more years of Medicare utilization data (2014 and 2015 data), October 2016.

### III. Work Neutrality Review (CPT 2012)

AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2012 cycle. It appeared that there were two issues where there was a large growth in utilization in the first year, Chronic Wound Dermal Substitute and Destruction by Neurolytic Agent.

#### Chronic Wound Dermal Substitute

The first issue was a large family of codes, 15271-15278. The specialty societies (ABA, ACS, APMA, ASBS and ASPS) reviewed the utilization data and discovered that CMS created two temporary G-codes for 2011 to report skin substitute application for lower extremity wounds, which were not included in the source utilization. Attached is a revised work neutrality review file that compares 2011, 2012 and 2013 and includes the G-codes and their 2011 RVW and utilization. In using the correct source utilization the total RVUs actually decreased; -5% (2011-2012) and -4% (2012-2013). **Therefore, this family of services was indeed work neutral as submitted. AMA staff provided the correct source data and work neutrality assumptions for Chronic Wound Dermal Substitute services to file for informational purposes.**

#### Destruction by Neurolytic Agent

In February 2011, the CPT Editorial Panel deleted four codes and created four new codes, CPT codes 64633-64636, to describe neurolysis reported per joint (2 nerves per each joint) instead of per-nerve and bundled image guidance.

In June 2014, the AMA staff analysis showed that in the year 2012 the Destruction by Neurolytic Agent codes was not budget work neutral and that, during the first year of the code's existence, there was 24% more utilization than projected. Therefore, the Relativity Assessment Workgroup review was initiated for this family.

The specialty societies have indicated in their action plan that the utilization numbers for this family of codes are climbing despite the fact that each code now describes one joint (two nerves), and the codes were billed per-nerve prior to 2012. There may be physicians who are still using the code on a per-nerve and not a per-joint basis. As such, they developed a *CPT Assistant* article (publication date: February 2015) stressing that each of these codes now includes the entire joint (i.e. two nerves) and not just one nerve, as before. Also, the specialty societies will perform additional education through their publications on this topic.

The Workgroup discussed this issue and agreed that the CPT Assistant article is a good proactive step. **The Workgroup recommended that the specialty societies submit revised introductory language to the CPT Editorial Panel immediately for CPT 2016 to address any inappropriate coding regarding reporting per nerve instead of per joint issue. The Workgroup requested that AMA staff compile data on how many times a service is reported on the same patient on the same day and 2014 preliminary Medicare utilization. The Workgroup will review the additional data and again review this issue in April 2015.**

#### IV. Action Plan Review (CPT codes 69210 & 76940)

##### **69210 Removal impacted cerumen requiring instrumentation, unilateral**

For CPT 2014, code 69210 was revised from *Removal impacted cerumen (separate procedure), 1 or both ears* to describe this service for only one ear (unilateral). In January 2013, the RUC recommended a work RVU of 0.58. The RUC flagged this service at the time of review noting: “Under current reporting, CPT code 69210 cannot be billed with the bilateral modifier (50). Therefore, there is no available claims data to substantiate accurate reporting. The RUC will review one year of Medicare claims data, once available, to determine if the 10% bilateral usage assumption is accurate.” In the Final Rule for 2014 CMS indicated that they did not believe this service will only be reported bilaterally 10% of the time and valued this service at 0.61

AMA staff noted that the 2014 Medicare preliminary data are not currently available for review. However, the specialty societies request that this service go to CPT for creation of another code to describe complex removal of cerumen. **The Workgroup agrees with the specialty societies that a new code be created to report complex removal of cerumen and that CPT code 69210 be removed from the MPC list.**

##### **76940 Ultrasound guidance for, and monitoring of, parenchymal tissue ablation**

In April 2014 the RUC reviewed the prior review history for CPT code 76940. During the time of the original valuation for this service, the original CPT code for ultrasound guidance for parenchymal tissue ablation, 76490, was renumbered by the CPT Editorial Panel to 76940 for CPT 2004. In February 2002, the RUC reviewed the specialty physician work RVU recommendations and determined that a work RVU of 4.00 was appropriate for this service. CMS accepted this value for 2003. However, when the code was renumbered in 2004, the Final Medicare Physician Payment Schedule listed the new code number, 76940, as 2.00 work RVUs. The error went unnoticed until these services were reviewed under the NPRM for the 2014 CMS screen. The RUC discussed that since this service is low volume, conducting a survey may not yield sufficient results to properly value this service. The Committee agreed with the specialty societies that the interested societies should bring forward an action plan for all three codes (76940, 76948 and 76965) to the Relativity Assessment Workgroup (RAW) at the September RUC meeting which provides a more robust analysis of the utilization and physician usage data. Until this review, the RUC recommends the current work values as interim for the following codes: a work RVU of 2.00 for CPT Code 76940, a work RVU of 0.38 for CPT code 76948 and a work RVU of 1.34 for CPT code 76965.

In September 2014 the Relativity Assessment Workgroup requested the specialty societies develop an action plan for January 2015 meeting to determine whether this should be submitted to CPT for revision or resurveyed.

The specialty societies indicated that they wish to refer this issue to create a CPT Assistant article to clarify the codes with which it may be reported. The Workgroup disagreed that a CPT Assistant article will address the inappropriate reporting of this low volume code. **The Workgroup agrees with the specialty societies that the code is not overvalued. The Workgroup recommends that the RUC flag CPT code 76940 as not to be used for**

**validation of physician work and for the specialty societies to submit a CCI edit indicating that 76940 should not be reported with the 30000 series ablation codes.**

**V. 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), James Georgoulakis, PhD, JD, David Hitzeman, DO, Charles Koopmann, Jr, MD, Walt Larimore, MD, Lawrence Martinelli, MD, Marc Raphaelson, MD, Sandra Reed, MD, Christopher Senkowski, MD, Peter Smith, MD, Samuel D. Smith, MD, Stanley W. Stead, MD, MBA, George Williams, MD

**I. Research Subcommittee October 28, 2014 Conference Call Meeting Report**

**The Research Subcommittee report from the October 2014 conference call is included in Tab 30 of the January 2015 agenda materials for approval by the RUC.**

**II. Research Subcommittee Guidelines and Requirements Document**

In follow up to previous Subcommittee discussion, Doctor Collins and AMA staff drafted a Research guidelines and requirements document for the Subcommittee's review and consideration at the January 2015 meeting in an effort to centralize Research Subcommittee rules and requirements. The review requirements included in the initial draft were consistent with the Subcommittee's current rules. The research request submission requirements were somewhat strengthened in an attempt to better facilitate the subcommittee's review of specialty society requests.

Several Subcommittee members expressed their general support for the document, commenting that having a concise, centralized document will help to improve and streamline the Subcommittee's review processes.

One Subcommittee member shared their thoughts that three portions of the document should be further strengthened, suggesting the following changes to the initial draft. The Subcommittee approved the following content modifications to the initial draft:

- Revise the review requirements for clinical vignettes so that if there is no existing vignette in the RUC database, then Research vignette review is required.
- Change the Survey sample language so it is explicitly stated that societies should describe the population used in their survey sample.
- Change the survey instrument review requirements so that Research review and submission of summary data is required, if an advisory committee desires to add a new question to the survey.

There was Subcommittee discussion regarding whether this new document would make future research review and approval of targeted survey sample requests unnecessary. Several Subcommittee members expressed their reservation with discontinuing the requirement for explicit research approval of targeted survey samples and the Subcommittee collectively decided to not change this review requirement.

In addition to the content changes, several editorial changes were also made to the initial draft. The final document is included below in *Appendix A*

**The Research Subcommittee recommends the adoption of the *Research Subcommittee Guidelines and Requirements* document, as written in Appendix A below.**

The Subcommittee requested for AMA staff to draft an appendix with definitions of terms used in the document (ie “targeted”, “sample”, etc.) for the Subcommittee’s review at its April 2015 meeting. The Subcommittee also requested for AMA staff to conduct analyses of the Subcommittee’s past review and approval of targeted survey sample requests (ie frequency, approval rate, etc.) Finally, the Subcommittee also asked AMA staff to track specialty feedback regarding the new rules document and provide that collated feedback at an upcoming Subcommittee meeting.

### III. **Introductory Text for Online RUC Survey Instrument**

At the September 2014 Research Subcommittee meeting, a specialty society staffer expressed their concern that the survey instrument starts abruptly with no introductory paragraph to explain the purpose of the survey instrument. The Subcommittee agreed that the lack of an introductory paragraph in the survey instrument was a concern and requested for AMA staff to draft a paragraph for the Subcommittee to review at the January 2015 meeting.

**The Subcommittee reviewed the draft text and approved the text for inclusion in the RUC Online Survey tool as follows** (note, the below text includes minor editorial changes Submitted by a Subcommittee member to the Subcommittee after the in-person meeting):

*You have been selected to participate in an AMA/Specialty Society RVS Update Committee (RUC) survey. As you may know, the components of the Medicare physician payment schedule are physician work, practice expense and professional liability insurance. This survey will help our society, in concert with the RUC, recommend accurate relative values for physician work to the Centers for Medicare and Medicaid Services. Each survey is comprised of questions relating to the physician work for one or more physician services.*

### IV. **Other Business**

#### **RUC Survey – Transition to the Online RUC Survey Tool (Informational Only) Overview of Updates to RUC Online Survey Tool and Process**

The Chair noted that an updated online survey timeline as well as an overview of updates to the online tool are provided in the agenda packet. It was noted that AMA staff are continuing to solicit feedback from specialty society staff utilizing Qualtrics. The feedback has resulted in editorial design/content improvements. The Research Subcommittee will be asked to review only significant staff suggestions at a future RUC meeting. The Chair stated that the survey is currently being used by two-thirds of surveying societies at each meeting, though there is no set date for when the tool will be mandatory for all societies to use. All specialties are strongly encouraged to use the Qualtrics survey tool for all future surveys.

#### **Intensity and Complexity Ratings**

Several Subcommittee members shared their confusion with how to interpret the new Intensity and Complexity measures. Other’s stated their thoughts that as the RUC had been using the old intensity and complexity rating scale for so long, that hopefully it would just take a little time for all RUC members to get a full grasp of the new rating scale.

The Chair explained that for the new intensity and complexity rating scale, the survey respondents are rating the survey code relative to the key reference code that they selected. The legend for the new survey intensity and complexity measures is as follows:

**Intensity/Complexity Rating Scale:** -2= Much Less Intense/Complex, -1= Somewhat Less Intense/Complex, 0= Identical Intensity/Complexity, +1= Somewhat More Intense/Complex and +2=Much More Intense/Complex

**The Chair requested for AMA staff to include explanatory text with examples in all future email communications to RUC members and RUC alternates during the initial RUC review period prior to each RUC meeting. The Chair also stated that the Summary of Recommendation form for the April 2015 meeting will be updated to include a small legend with the new rating scale.**

**Appendix A:**

**Research Subcommittee Guidelines and Requirements**

- I. General Guidelines:** When your Advisory Committee (AC) submits a request to the Research Subcommittee, it is strongly recommended for the submission to include a short written rationale which includes codes and code descriptors, relevant background information, why the request is being submitted and the reasoning for why any proposed changes are warranted (when applicable).
- II. Clinical Vignettes (“Typical Patient”):**
  - a. Review Requirements:** For new and revised codes, Research Subcommittee approval is required if you would like to use a modified vignette which deviates from the version approved by the CPT Editorial Panel. For CMS and Relativity Assessment Workgroup requests for existing codes, if you want to survey using a modified vignette, distinct from what is available in the RUC database, then that would require Research Subcommittee approval as well.
  - b. Submission Requirements:** If an AC would like to request for the Research Subcommittee to review a vignette, the specialty society must submit the proposed vignette which should reflect the typical patient and also provide the existing vignette, either approved by the CPT Editorial Panel or the vignette listed in the RUC Database.
- III. Survey Sample Methodology:**
  - a. Review Requirements:** The RUC expects ACs to use a random survey to develop relative value recommendations and should disclose the process used and the population sampled in the rationale section of Summary of Recommendation (SOR) form. If a specialty intends to use any other survey sample method, they must request review and approval by the Research Subcommittee prior to surveying the code(s).
  - b. Submission Requirements:** Submission must define the source of any proposed targeted sample and should explicitly state whether the AC intends to use only a targeted survey sample, both targeted and random samples or a survey which includes all names on the targeted list. Inclusion of a short written rationale with your Research Subcommittee request is strongly recommended.



c. **Requirements pertaining to your RUC Submission and Presentation:**

- i. If a Research Subcommittee approved “targeted survey” consists of contact information provided from a company/vendor, the specialty society must have the company/vendor sign the RUC Company/Vendor Attestation Statement stating no further communication regarding the survey or valuation occurred.
- ii. If the Research Subcommittee approves of survey sample methodology which includes both a targeted sample and a random sample, the summary data would need to have targeted and random samples presented separately and together to the RUC. The summary data must be listed both separately and together in the summary excel spreadsheet and the SOR rationale section must summarize the separated and aggregated survey data.

IV. **Reference Service Lists (“RSLs”):**

- a. **Review Requirements:** Research review and approval of a RSL is **NOT mandatory**, though can be beneficial under certain circumstances (ie if there are few appropriate reference codes to choose from when creating your RSL).
- b. **Submission Requirements:** If an AC would like to have the Research Subcommittee review a proposed reference service list, the RSL must adhere to the following process:
  - i. The RSL should adhere to the reference service list guidelines
  - ii. Include all survey codes on the RSL if existing work RVUs are available (**for Subcommittee reference purposes only**)
  - iii. The RSL must be sorted by work RVU, lowest to highest
  - iv. For each code on the proposed RSL, provide the following data points so that the Research Subcommittee can critically review the list:
    - 1.) CPT Code Number
    - 2.) CPT Descriptor
    - 3.) Current work RVUs
    - 4.) The year it was valued
    - 5.) Whether the time is based on RUC, Harvard or other
    - 6.) The MPC status
    - 7.) The Medicare Volume
    - 8.) The intra-service time
    - 9.) The total service time
    - 10.) The IWPOT calculation

V. **Modifications to Standard RUC Survey Templates:**

- a. **Review Requirements:** Research review and approval is required if your AC desires to modify or remove any content and/or questions from the standard RUC Survey templates. Exemptions to this requirement include: removal of the moderate sedation question when it is not applicable to the survey code, modification to the contact information question, or using a single survey instrument to survey multiple codes with different global periods (as long as only standard survey template language is utilized). Research Subcommittee approval is required when adding a new question to your Survey template and reporting of summary data from that new question is required.

- b. **Submission Requirements:** Submission of a red-line version of all proposed modifications to the standard survey instrument is required. Inclusion of a short written rationale with your Research request is strongly recommended.
- c. **Requirements pertaining to your RUC Submission:** As is required for all RUC surveys, submit a copy of your RUC survey template to AMA staff. If you add a new question to your RUC Survey template, you must report the summary data for that new question in your SOR rationale.

**VI. Educational Materials:**

- a. **Review Requirements:** If a RUC process or RUC survey presentation is altered from the standard version, the revised presentation would require Research Subcommittee review and approval. Likewise, if a presentation is presented (either in person or electronically) to a society's membership then it is required to have a Research Subcommittee member and an AMA staff member present to proctor the presentation.
- b. **Submission Requirements:** Submission must include the proposed educational material and a short written rationale for the modifications to the standard versions of the presentations.

**Members:** Doctors James Blankenship (Chair), Margie Andreae, Thomas Cooper, Anthony Hamm, Walt Larimore, Marc Leib, Greg Przybylski, Sandra Reed, David Regan, Samuel D. Smith, and James Waldorf

**506XX6 Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

The Facilitation Committee members had a detailed conversation about the RUC's concerns regarding the global period used for this code. The specialty confirms that this code is almost always billed with another code. Since it was designated by CPT as -51 modifier exempt, the RUC was concerned that the pre- and post-service work would be duplicative.

The specialty suggested that the surveyees had assumed that the code was a stand-alone code, and therefore assigned it pre- and post work, The Facilitation Committee recommends and the specialty agrees that it is most reasonable for code to be referred back to CPT. This will allow the specialty to re-survey the code, this time as an add-on procedure, with a new recommendation brought to the RUC at the April 2015 meeting. **The Facilitation Committee recommends code 506XX6 be referred back to CPT.**

**507XX11 Ureteral embolization or occlusion, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

**The Facilitation Committee recommends code 507XX11 be referred back to CPT.**

The Facilitation Committee members had a detailed conversation about the RUC's concerns regarding the global period used for this code. The specialty confirms that this code is almost always billed with another code. Since it was designated by CPT as -51 modifier exempt, the RUC was concerned that the pre- and post-service work would be duplicative.

The specialty suggested that the surveyees had assumed that the code was a stand-alone code, and therefore assigned it pre- and post work, The Facilitation Committee recommends and the specialty agrees that it is most reasonable for code to be referred back to CPT. This will allow the specialty to re-survey the code, this time as an add-on procedure, with a new recommendation brought to the RUC at the April 2015 meeting. **The Facilitation Committee recommends code 507XX11 be referred back to CPT.**

**507XX12 Balloon dilation, ureteral stricture, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

The Facilitation Committee members had a detailed conversation about the RUC's concerns regarding the global period used for this code. The specialty confirms that this code is almost always billed with another code. Since it was designated by CPT as -51 modifier exempt, the RUC was concerned that the pre- and post-service work would be duplicative.

The specialty suggested that the surveyees had assumed that the code was a stand-alone code, and therefore assigned it pre- and post work. The Facilitation Committee recommends and the specialty agrees that it is most reasonable for code to be referred back to CPT. This will allow the specialty to re-survey the code, this time as an add-on procedure, with a new recommendation brought to the RUC at the April 2015 meeting. **The Facilitation Committee recommends code 507XX12 be referred back to CPT.**

**AMA/Specialty Society RVS/Update Committee**  
**Facilitation Committee #2**  
**Tab 10 - Penile Trauma Repair**

**Tab 10**

Committee Members: Doctors Hitzeman (Chair), Bishop, Blasier, Burd, Koopmann, Neal, Raphaelson, Rubin, Smith and Jane White

***5443X1 Repair of traumatic corporeal tear(s)***

The Facilitation Committee discussed several key issues addressed by the RUC during their discussion at the table for CPT code 5443X1.

First, the Committee members confirmed the changes that the specialty society made to their recommendation at the table. The specialty is now recommending the 25<sup>th</sup> percentile work RVU of 11.50. The specialty modified the pre-service time to the standard package 3- Facility straightforward patient, difficult procedure. Finally, the specialty also removed the initial hospital visit (99233), as the survey data did not show an E/M was typical on the same day.

Second, there was discussion at the table concerning potential overlap between an E/M service billed on the same date due to the emergent nature of this procedure. It was noted that the Practice Expense Subcommittee, the previous day, discussed the necessary pre-service clinical labor during this tab and realized that the Subcommittee and the RUC have previously accepted varying time elements for emergent procedures. Therefore, it was decided that AMA staff will go back and perform an exhaustive search of emergent procedure previously valued by the RUC to determine precedence for establishing pre time. Due to this upcoming review, and to remain consistent, the Facilitation Committee did not decrement any physician time at this meeting.

Third, the Committee discussed whether or not the four post-operative E/M visits all met the threshold for a 99213. The specialty agreed to reduce the fourth E/M visit to a 99212, as this final visit is simply assessing the penial rehabilitation response from a previous visit.

**Given these changes, the Facilitation Committee agreed with the specialty society on a work RVU of 11.50 for CPT code 5443X1, with pre-service time of 51 minutes, intra time of 60 minutes and post-service time of 30 minutes. The post-operative visits include a full-day discharge (99238) and four post-operative E/M visits (3 99213s and 1 99212).**

***5443X2 Replantation, penis, complete amputation***

The Facilitation Committee agreed with the specialty society that specialty's recommended physician times were accurate for CPT code 5443X2: pre-service time of 58 minutes, intra-service time of 180 minutes and post-service time of 28 minutes. The Committee also agreed that the following number of visits was necessary due to the extremely high level of complexity of the patient who is typically schizophrenic and the time intensive nature of the continuous follow-up care: hospital visits (two 99232s and one 99233), discharge management (one 99238) and office E/M visits (four 99213s).

The Facilitation Committee agreed with the specialty's recommendation of the median work RVU of 24.50. This median work value compares well to the key reference service 53448 *Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue* (work RVU= 23.44, intra time= 170 minutes).

**The Facilitation Committee recommends a work RVU of 24.50 for CPT code 5443X2.**

The Facilitation Committee had no changes to the modified Practice Expense spreadsheets as approved by the PE Subcommittee.

**AMA/Specialty Society RVS Update Committee**  
**Tab 11 Intrastomal Corneal Ring Implantation**  
**Facilitation Committee #3**

Members Present: Geraldine McGinty, MD (Chair), John Agens, MD, Margie Andreae, MD, Scott Collins, MD, Robert Kossmann, MD, Alan Lazaroff, MD, Len Lichtenfeld, MD, William J. Mangold, Jr, MD, Joseph Schlecht, DO, Stanley Stead, MD

*657X7 Implantation of intrastomal corneal ring segments*

The Facilitation Committee had a detailed discussion with the specialty societies about the aspects of this new technology service, including the physician work and time involved.

The Committee reviewed the survey results from 34 ophthalmologists and agreed with the specialty on the following physician time components: a pre-service time of 23 minutes, an intra-service time of 30 minutes and an immediate post-service time of 10 minutes.

The Committee also agreed with the specialty that the following office visits during the 90-day global period were justified: one 99212 office visit 1 day after the procedure to confirm alignment of the corneal ring, one 99212 office visit 1-2 weeks post-op to confirm examine healing, potential inflammation and that the corneal ring is still in place, one 99213 office visit to remove the sutures, and one 99212 office visit 3 months out to confirm the results of the procedure.

The Facilitation Committee considered recommendations forwarded from the full RUC, including recommended values and potential crosswalks. To determine an appropriate work value, the Committee compared the survey code to CPT code 67917 *Repair of ectropion; extensive (eg, tarsal strip operations)* (work RVU=5.93, intra-time of 33 minutes, total time of 142 minutes) and noted that both codes have similar intra-service times, total times and intensities, they should be valued similarly. Therefore, the Facilitation Committee recommends a direct work RVU crosswalk from code 67917 to code 657X7. To further support this recommendation, the Committee examined CPT Code 67916 *Repair of ectropion; excision tarsal wedge* (work RVU=5.48, intra-time of 25 minutes, total time of 134 minutes) and CPT Code 25605 *Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation* (work RVU=6.25, intra-time of 30 minutes, total time of 169 minutes), and agreed that the survey code recommendation is appropriately bracketed by these two reference services.

**The Facilitation Committee recommends a work RVU of 5.93, a pre-service time of 23 minutes, an intra-service time of 30 minutes and an immediate post-service time of 10 minutes for CPT code 657X7.**

The Facilitation Committee had no changes to the modified Practice Expense spreadsheets as approved by the PE Subcommittee.