AMA/Specialty Society RVS Update Committee
Meeting Minutes
January 13-16, 2016

I. Welcome and Call to Order

Doctor Peter Smith called the meeting to order on Thursday, January 14, 2016 at 1:00 pm. The following RUC Members were in attendance:

Peter K. Smith, MD	Amr Abouleish, MD, MBA*
Margie C. Andreae, MD	Jennifer Aloff, MD*
Michael D. Bishop, MD	Allan A. Anderson, MD*
James Blankenship, MD	Gregory L. Barkley, MD*
Dale Blasier, MD	Eileen Brewer, MD*
Albert Bothe, MD	Jimmy Clark, MD*
Ronald Burd, MD	Joseph Cleveland, MD*
Scott Collins, MD	William D. Donovan, MD, MPH, FACR*
Gregory DeMeo, MD	Jeffrey Paul Edelstein, MD*
Jane Dillon, MD	William E. Fox, MD, FACP*
Verdi. J DiSesa, MD	Michael J. Gerardi, MD, FACEP*
James Gajewski, MD	Peter Hollmann, MD*
William F. Gee, MD	John Lanza, MD*
David F. Hitzeman, DO	Mollie MacCormack, MD*
Robert Kossmann, MD	Paul Martin, DO, FACOFP*
Walt Larimore, MD	Daniel J. Nagle, MD*
Alan Lazaroff, MD	Scott D. Oates, MD*
M. Douglas Leahy, MD, MACP	Sandra Reed, MD*
Scott Manaker, MD, PhD	M. Eugene Sherman, MD*
Geraldine B. McGinty, MD	Samuel Silver, MD*
Margaret Neal, MD	Holly Stanley, MD*
Guy Orangio, MD	Robert J. Stomel, DO*
Gregory Przybylski, MD	Michael J. Sutherland, MD, FACS*
Marc Raphaelson, MD	G. Edward Vates, MD*
Joseph Schlecht, DO	Adam Weinstein, MD*
Christopher K. Senkowski, MD, FACS	
Stanley W. Stead, MD, MBA	
James C. Waldorf, MD	
Jane White, PhD, RD, FADA, LDN	
Jennifer L. Wiler, MD	
George Williams, MD	*Alternate

II. Chair's Report

- Doctor Smith welcomed everyone to the RUC Meeting.
- Doctor Smith welcomed the Centers for Medicare & Medicaid Services (CMS) staff and representatives attending the meeting, and asked that Doctor Hambrick introduce the staff during her update.
- Doctor Smith welcomed the following Contractor Medical Directors:
    - Charles Haley, MD, MS, FACP
- Doctor Smith welcomed the following Members of the CPT Editorial Panel:

  - Kathy Krol, MD – Panel Member Observer
  - Jordan Pritzker, MD – Panel Member Observer
- Doctor Smith welcomed new RUC members:
  - Gregory DeMeo, MD
  - Doug Leahy, MD
- Doctor Smith welcomed new RUC alternate members:
  - William E. Fox, MD
- Doctor Smith welcomed the following Observers:
  - Ezekiel Emanuel, MD, PhD
    - Chair, Medical Ethics & Health Policy at the University of Pennsylvania
  - Maura Calsyn
    - Director of Health Policy at the Center for American Progress
- Doctor Smith welcomed the following Researcher:
  - Armando Lara-Millan, PhD
    - RWJF Scholars in Health Policy Research Program University of California, Berkeley/UCSF
    - Proposed a scientific publication related to his observations of the RUC process.
    - All observations de-identified, publication to be reviewed by AMA
    - Publication to be delayed by 1 year, so that code values will be finalized
    - Individual interviews will be accompanied by individual consent, and will be voluntary
- Doctor Smith explained 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 Smith laid out the following guidelines related to confidentiality:
  - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement at the registration desk)
  - This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.
- Doctor Smith shared the following procedural rules for RUC members:
  - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes
  - RUC members or alternates sitting at the table may not present or debate for their society
  - Expert Panel – RUC Members exercise their independent judgment and are not advocates for their specialty
- Doctor Smith laid out the following procedural guidelines related to 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 Smith shared 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
      To insure we have 28 votes, please share voting remotes with your alternate if you step away from the table
    - 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 Smith 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.

III. Director's Report

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

- There will be a reception following this meeting to celebrate the service of long time RUC member, Doctor Leonard Lichtenfeld.
- Because of that reception and the Surgical Workgroup, which will meet in this room at 7am tomorrow morning, the first facilitation meetings will not be until lunch tomorrow.
- Ruby Overton-Bridges is on medical leave, she is doing very well and will be returning to work in February.
- Sherry Smith welcomed new RUC staffer Kristina Finney, who is a Senior Policy Analyst at the AMA and joining us for the first time at this meeting.

IV. CPT Editorial Panel Update (Informational)

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

- The CPT Editorial Panel last met in Philadelphia in October.
- At the last CPT meeting we further refined the definition of acceptable literature to support a category I code. That had to do with the publication status of literature, when it was in press and when it was available for review at a CPT meeting.
- CPT further refined modifier 33, the modifier attached to preventative services, to make it more precise about what category rating an item needs from US preventative services task force to get that designation.
- CPT is working to develop a new section in the CPT manual; it will be a subsection of the pathology section brought to us by Protecting Access to Medicare Act (PAMA) passed by Congress. One of the sections of this act has to do with two version of proprietary laboratory analysis, the first done by a single laboratory and the second done by multiple laboratories.
- CPT will meet in two weeks. In addition to the regular agenda CPT will be reviewing the following:

- A proposal to sundown 26 category III (emerging technology) codes that have not been used and there is no sponsor to maintain them.
- Review 92 category I codes that are rarely used in the US healthcare for possible deletion. These are codes that have less than ten claims in the past year through Medicare, BCBS and Aetna. The three organizations account for over 100 million covered members.
- A proposal from a workgroup on telehealth for an appendix in the CPT manual to list all the codes which have been approved for a telehealth modifier. There are approximately 90 now and we expect more as we move into an increasingly electronic world.

V. Approval of Minutes of the October 1-3, 2015 RUC Meeting

- **The RUC approved the October 2015 RUC Meeting Minutes as submitted.**

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

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

- Doctor Hambrick introduced staff from CMS attending this meeting
  - Edith Hambrick, MD - CMS Medical Officer
  - Geri Mondowney – Health Insurance Specialist
  - Steve Phurrough, MD - CMS Medical Officer
  - Michael Soracoe - Research Analyst
  - Marge Watchorn - Deputy Director, Division of Practitioner Services
- There will be a listening session for surgical globals on January 20th. Further information is on the CMS website.
- Now is the time to come see the Agency about the notice of proposed rule making (NPRM). Due to the change in the schedule, CMS is requesting that you comment even earlier this cycle.
- A RUC member asked if there was a shift in policy regarding the concept of intensity, given that in the last rule we saw linear decreases in time correspond to linear reductions in value.
  - CMS responded that when they do not accept the RUC recommendation the rationale for that decision is provided. The rationale should be taken at face value. It is not necessarily saying anything about intensity, rather it is saying for the value of that code this is how the agency came to a different resolution then the RUC did.

VII. Contractor Medical Director Update (Informational)

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

- ICD-10 went into effect in October and there have been very few problems so far. There were a few contractor edit or policy specific problems or national edit or policy specific problems. Most of these have been resolved except for a few that are still pending.
- There are currently no new contracts.
- Before we last met in October, Jurisdiction 15 had been awarded to CGS the incumbent there were no protest and that transition is underway

- Two DME MAC contracts were not awarded to the incumbent. JB was awarded to CGS. JA (northeastern states) was awarded to Noridian.
- Special billing arrangements for off campus facilities. Since 2003 hospitals were required to identify to the contractors and CMS those outpatient clinics not on their main campus. The campus is defined as the main hospital building and the surrounding 250 yards. As of January 2015 hospitals were suppose to identify any services billed from these off campus facilities with a PO modifier. As of January 2016 this is a mandatory requirement. For physicians, this means if you are working in an off campus outpatient facility you are suppose to identify the physicians claim with a place of service 19 rather then a place of service 22. As of next year January 2017, CMS will have a new payment structure for the facility fees for these off campus outpatient facilities.

VIII. Relative Value Recommendations for *CPT 2017*:

Bone Biopsy (Tab 4)
William Creevy MD (AAOS); John Heiner MD (AAOS)

In January 2014, CPT code 20245 was identified by the 010-Day Global Post-Operative Visits Screen and code 20240 was added as a family code for review of physician work and practice expense. 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. At the January 2015 RUC meeting, the RUC approved a physician work value for 20240. However, CPT code 20245 was not reviewed and was referred to the Research Subcommittee to approve a new survey sample. Under further review, the specialty societies determined that the code should be submitted to the CPT Editorial Panel to revise the descriptor to better specify examples of a deep bone biopsy. The CPT Editorial Panel approved these changes at the October 2015 meeting and the specialty presented work values and practice expense at the January 2016 RUC meeting.

20240 ***Biopsy, bone, open; superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)***
The RUC noted that the CPT descriptor changes to code 20240 were editorial, simply providing additional examples of superficial bones, including "calcaneus" which was included in the typical patient vignette. The CPT Editorial Panel and the RUC agreed that the edits did not change the inherent work involved in the service. Therefore, the RUC re-affirmed the recommendations made for this code at the January 2015 RUC meeting:

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 25th 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, humeral shaft, ischium, femoral shaft)*
The specialty societies presented compelling evidence that the previous valuation was flawed and was surveyed in error as a 90-day global code using a 90-day global reference service list which after RUC and CMS review resulted in almost zero intra-service work. That is to say the RUC and CMS corrected the work RVU, but not the visit details. The RUC agreed that the previous survey was flawed and also agreed that the current review should compare the physician work to other 0-day global codes for accurate relativity.

The RUC reviewed the survey results from 61 orthopaedic surgeons and agreed with the specialty societies on the following time components: pre-service time of 70 minutes, intra-service time of 60 minutes and immediate post-service time of 30 minutes. The RUC agreed that 12 minutes of positioning time above the pre-service time package (4- Facility, difficult patient, difficult procedure) was warranted to place the patient in the lateral decubitus position. This time has been previously approved for CPT code 27130 *Total hip arthroplasty* (reviewed by the RUC in 2012).

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey median of 6.50 work RVUs is appropriate for this procedure as a 0-day global code. To justify a work RVU of 6.50, the RUC compared the surveyed code to the second key reference code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58, intra time= 45 minutes) and noted that since code 20245 has 15 additional minutes of intra-service time, the recommended value apporpriately places the code higher than this reference code and maintains a similar intra-operative intensity. The RUC also reviewed 19 codes with a 000-day global period and 60 minutes of intra-time that were reviewed by the RUC and finalized by CMS between 2011 and 2015. and noted that a work RVU of 6.50 approximately fit in the middle of these services. Two additional reference codes that closely bracketed the recommended value are: 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, intra time= 60 minutes) and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* (work RVU= 6.60, intra time= 60 minutes). Finally, the RUC discussed the decrease in intra-service time from the current time (90 minutes) to the survey time (60 minutes). It was explained that the current time was based on a survey of 35 indivdiuals over 15 years ago. Furthermore, due to the previous flawed survey, the resulting IWPUT was almost zero Given these

discrepenacies, the survyed time of 60 minutes better reflects an appopriate level of intensity and complexity (IWPUT= 0.071) for this service relative to other 000-day global procedures.
The RUC recommends a work RVU of 6.50 for CPT code 20245.
Practice Expense:
The Practice Expense Subcommittee discussed and approved the usual 000-day global inputs, with extensive use of the clinical staff supplemented by a telephone call. The RUC approved the modification as approved by the Practice Expense Subcommittee.

Insertion of Spinal Stability Distraction Device (Tab 5)
John Ratliff, MD (AANS); Alexander Mason, MD (CNS); Henry Woo, MD (CNS); Charles Mick, MD (NASS); Karin Swartz, MD (NASS); Morgan Lorio, MD (ISASS); William Creevy, MD (AAOS); John Heiner, MD (AAOS)

At the May 2015 CPT meeting, the CPT Editorial Panel converted two Category III codes to Category I and added two Category III codes to describe the insertion of the interlaminar/interspinous process stability device. The specialty societies noted that, during their survey process, they learned that a CPT code change proposal to create Category I codes for insertion of spinal stability distraction device without decompression was submitted for consideration for the October 2015 CPT Editorial Panel meeting. The societies noted the codes in this new CPT proposal are closely related to those that were surveyed for the October 2015 RUC meeting , and therefore, requested for postponing consideration of CPT codes 22840, 228X1 and 228X2 until the January 2016 RUC meeting so both code sets could be reviewed simultaneously. The RUC agreed that the specialty societies should present CPT codes 22840, 228X1 and 228X2 at the January 2016 RUC meeting concurrently with the new CPT codes for insertion of spinal stability distraction device without decompression. At the October 2015 CPT meeting, the CPT Editorial Panel converted two Category III codes to Category I codes to report insertion of spinous distraction device(s) without concurrent performance of open decompression.

22840 ***Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)***
The specialty societies noted and the RUC agreed that CPT code 22840 is not part of the same code family as the new spinal stability distraction device codes. CPT code 22840 is part of a different family of rigid fixation codes intended to be used for spinal fusion and with additional fusion codes. This service is commonly performed with minimal open exposure, often on an outpatient basis, and has little in common with the technique of transarticular screw fixation, which is an open procedure performed on an inpatient basis.

228X1 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level***
The RUC reviewed the survey results from 58 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed on the following physician time components: pre-service time of 63 minutes (pre-time package of 3 with 12 minutes added to the standard package for positioning), intra-service time of 90 minutes and immediate post-service time of 30 minutes (post-service package 9B with 3 minutes removed from the standard package). The median survey immediate post-operative time was 20 minutes, though the CMS' 23-hour stay rule was also applied to this outpatient service. To apply CMS' rule, the intra-service time was reallocated from the same-day Evaluation and Management (E/M) code 99231 to the

immediate post-service time (adding 10 minutes to the intra-service time). A majority of respondents (87%) indicated that the typical patient will stay overnight or be admitted. Of the survey respondents that indicated the patient was kept overnight, the majority indicated that the typical patient will require an E/M visit later the same day. 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 three 99213 office visits during the 090-day global period are typical.

The RUC reviewed the survey 25th percentile physician work value and agreed that the survey respondents overvalued the work involved in performing this service. To determine an appropriate work value for 228X1, the RUC reviewed CPT code 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)* (work RVU=15.00, intra-service time of 90 minutes, total time of 270 minutes) and noted that both services have similar physician work, identical intra-service time and nearly identical total time. Given these similarities, the RUC recommends a work RVU of 15.00, which is a direct crosswalk to CPT code 29915. To justify this value, the RUC compared 228X1 to CPT code 29916 *Arthroscopy, hip, surgical; with labral repair* (work RVU=15.00, intra-service time of 90 minutes, total time of 270 minutes) and noted that both services have similar physician work, identical intra-service time and nearly identical total times. **The RUC recommends a work RVU of 15.00 for CPT code 228X1.**

228X2 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 49 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed on the following physician time components: intra-service time of 45 minutes.

The RUC reviewed the surveyed 25th percentile work RVU of 4.00 and agreed with the specialties that this value appropriately accounts for the physician work involved. To justify a work RVU of 4.00, the RUC compared the survey code to MPC code 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU=4.88, intra-service time of 45 minutes) and noted that both services have identical intra-service time and total time, supporting the proposed work RVU for the survey code. The RUC also reviewed CPT code 37237 *Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)* (work RVU= 4.25, intra-service time of 45 minutes, total time of 47 minutes) and noted that both services have similar physician work, identical intra-service times and similar total times. **The RUC recommends a work RVU of 4.00 for CPT code 228X2.**

228X4 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level***
The RUC reviewed the survey results from 58 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed on the following physician time components: pre-service time of 63 minutes (pre-time package of 3 with 12 minutes added to the standard package for

positioning), intra-service time of 43 minutes and immediate post-service time of 30 minutes (post-service package 9B with 3 minutes removed from the standard package). The median survey immediate post-operative time was 20 minutes, though the CMS' 23-hour stay rule was also applied to this outpatient service. To apply CMS' rule, the intra-service time was reallocated from the same-day E/M code 99231 to the immediate post-service time (adding 10 minutes to the intra-service time). A majority of respondents (71%) indicated that the typical patient will stay overnight or be admitted. Of the survey respondents that indicated the patient was kept overnight, the majority indicated that the typical patient will require an E/M visit later the same day. 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 99213 office visit and one 99212 office visit during the 090-day global period are typical.

The RUC reviewed the survey 25th percentile physician work value and agreed that the survey respondents overvalued the work involved in performing this service. To determine an appropriate work value for 228X4, the RUC reviewed CPT code 29880 *Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed* (work RVU= 7.39, intra-service time of 45 minutes, total time of 199 minutes) and noted that both services have similar physician work, near identical intra-service times, though the survey code has more total time. Given these similarities, the RUC recommends a work RVU of 7.39, which is a direct crosswalk to CPT code 29880. To justify this value, the RUC compared 228X4 to CPT code 22511 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral* (work RVU= 7.58, intra-service time of 45 minutes, total time of 160 minutes) and noted that both services have similar physician work, near identical intra-service times, though the survey code has more total time. **The RUC recommends a work RVU of 7.39 for CPT code 228X4.**

228X5 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 49 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed on the following physician time components: intra-service time of 30 minutes.

The RUC reviewed the survey 25th percentile physician work value and agreed that the survey respondents overvalued the work involved in performing this service. To determine an appropriate work value for 228X5, the RUC reviewed CPT code 22103 *Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)* (work RVU= 2.34, intra-service time of 30 minutes) and noted that both services have similar physician work, identical intra-service and total times. Given these similarities, the RUC recommends a work RVU of 2.34, which is a direct crosswalk to CPT code 22103. To justify this value, the RUC compared 228X5 to 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 note that both services have identical intra-service times and total times, whereas the survey code involves somewhat more intensity. **The RUC recommends a work RVU of 2.34 for CPT code 228X5.**

New Technology
These services 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 minor modifications as approved by the Practice Expense Subcommittee.

Biomechanical Device Insertion – Intervertebral, Interbody (Tab 6)
John Ratliff, MD (AANS); Alexander Mason, MD (CNS); Henry Woo, MD (CNS); Charles Mick, MD (NASS); Karin Swartz, MD (NASS); Morgan Lorio, MD (ISASS); William Creevy, MD; (AAOS); John Heiner, MD (AAOS)

Facilitation Committee #2

At the October 2015 CPT meeting, the CPT Editorial Panel establish three new Category I codes to provide more detailed descriptions of placement and attachment of biomechanical spinal devices and deleted code 22851 throughout the code set.

22X81 ***Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 85 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed on the following physician time components: intra-service time of 45 minutes.

The RUC reviewed the survey respondents' 25th percentile physician work value and agreed that the survey respondents overvalued the work involved in performing this service. To determine an appropriate work value for 22X81, the RUC reviewed CPT code 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU = 4.88, 45 minutes total time) and noted that both services have similar physician work, as well as identical intra-service and total time. Given these similarities, the RUC recommends a work RVU of 4.88, which is a direct crosswalk to CPT code 57267. To justify this value, the RUC compared 22X81 to CPT code 35600 *Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)* (work RVU= 4.94, intra-service time of 40 minutes) and noted that although the survey code has more intra-service time, the reference code is somewhat more intense, justifying a similar valuation between both services. **The RUC recommends a work RVU of 4.88 for CPT code 22X81.**

22X82 ***Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges) when performed to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect***
The RUC reviewed the survey results from 85 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed on the following physician time components: intra-service time of 60 minutes.

The RUC reviewed the survey respondents' 25th percentile physician work value and agreed that the survey respondents overvalued the work involved in performing this service. To determine an appropriate work value for 22X82, the RUC reviewed CPT code 37234 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)* (work RVU = 5.50, 60 intra-service time, 62 minutes total time) and noted that both services have similar physician work, as well as identical intra-service and total time. Given these similarities, the RUC recommends a work RVU of 5.50, which is a direct crosswalk to CPT code 37234. To justify this value, the RUC compared 22X82 to 2nd key reference code 22858 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)* (work RVU= 8.40, intra-service time of 75 minutes) and noted that the survey code has a lower IWPUT (0.092 vs 0.112), while at the same time being rated as having higher intensity/complexity by the survey respondents, supporting the recommended valuation of 5.50 RVUs for the survey code. **The RUC recommends a work RVU of 5.50 for CPT code 22X82.**

22X83 ***Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 85 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed on the following physician time components: intra-service time of 60 minutes.

The RUC reviewed the respondents' 25th percentile work RVU of 6.00 and agreed that this value appropriately accounts for the physician work involved. The RUC noted that survey code 22X83 is a more intense/complex service than 22X83, indicating a higher work value for 22X83 is warranted. To justify a work value of 6.00, the RUC compared the survey code to CPT code 22534 *Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU= 5.99, intra-service time of 60 minutes) and noted that both services have identical intra-service time and involve a similar amount of physician work. To further confirm a work RVU of 6.00, the RUC reviewed CPT code *Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)* and noted that both service have identical intra-service time and involve a similar amount of physician work. **The RUC recommends a work RVU of 6.00 for CPT code 22X83.**

Practice Expense
There are no direct practice expense inputs for CPT codes 22X81-22X83 because these services are facility-only add-on services.

<u>Closed Treatment of Pelvic Ring Fracture (Tab 7)</u>
William Creevy MD (AAOS); John Heiner MD (AAOS)

In the Final Rule for 2014, CMS proposed CPT codes 21800, 22305 and 27193 for review to consider the appropriateness of having a 90-day global surgical package for a procedure that

is performed in settings other than the inpatient setting 33 percent of the time. CMS believed that it is unlikely that it is appropriate for a procedure performed outside of the inpatient hospital setting at this frequency to have such a long global period. The specialties reviewed the data for code 27193 and determined that the utilization for this work is bimodal; higher energy fractures in typically non-Medicare patients requiring careful monitoring to determine if / when surgery is appropriate and isolated lower energy fractures that are more typical of those acquired in falls from standing in Medicare-aged patients that typically will not require surgery, with work reported with Evaluation and Management (E/M) service codes. Codes 27193 and family code 27194 were referred to CPT and in October 2015, the CPT Editorial Panel deleted codes 27193 and 27194 and created two new codes 271X1 and 271X2 to differentiate higher energy fractures and isolated lower energy fractures. In addition, a parenthetical was added to direct physicians to use E/M coding for the closed treatment of isolated lower energy fractures of the anterior pelvic ring (typically low energy falls from standing in the elderly) to distinguish these injuries from the higher energy and more unstable posterior pelvic ring injuries that may also include the anterior elements of the pelvic ring simultaneously. The inherently stable anterior only fracture should not require close monitoring, manipulation, or treatment and therefore can be reported with an E/M service when diagnosed. These coding changes should address the issue of site of service because a patient with a high energy impact injury would not present to an office setting and would/should not be treated in an office setting.

271X1 ***Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation***

The RUC reviewed the survey results from 56 orthopaedic surgeons and recommends the following physician time components: pre-service time of 12 minutes, intra-service time of 5 minutes, immediate post-service time of 10 minutes, and appropriate postoperative hospital and office visits. Pre-service package 2b (difficult patient/straightforward procedure) was reduced from 18 minutes to 12 minutes to account for overlap with an E/M service that would typically be reported in conjunction with 271X1.

The RUC reviewed the survey 25th percentile of 5.50 work RVUs, with total time of 180 minutes, and determined it appropriately accounts for the physician work required to perform this service. The RUC agreed with the specialties that this new code and associated guidelines more clearly identify higher energy fractures in patients that will be admitted to the hospital. The RUC determined that one 99232 and one 99231 inpatient visit are justified because the typical trauma patient related to the new code will require careful monitoring to determine if / when surgery is appropriate. High energy pelvic ring fractures most often occur in conjunction with other trauma, so maintaining a 90-day global period allows for reporting of work related to multiple injuries in different anatomical locations. Specifically, high energy impact that results in a pelvic ring fracture may also result in a femur fracture or other spinal or lower extremity injuries. The stability of the posterior pelvic ring fracture cannot be assessed until other injuries are stabilized as they interfere with the ability to mobilize the patient. For example, after repair of a femur fracture, the posterior pelvic ring fracture will be monitored for instability or displacement to determine if/when surgery is necessary. This work is distinctly different than the post-operative work for open repair of a femur fracture. In addition, E/M codes cannot be reported to monitor the pelvic ring fracture during the global period of the femur fracture. At these visits the physician will remove the immobilizer, assess circulation, sensation, and motor function of pelvis and will follow the patient through healing and restoration of function if surgery is not required.

The RUC compared the service to key reference services CPT code 27267, *Closed treatment of femoral fracture, proximal end, head; without manipulation* (work RVU = 5.50, total time of 171 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, total time of 169 minutes) and noted that the two codes have similar total time to surveyed code 271X1. The intra-service time is higher for both key reference codes because this time category includes fabrication of a cast/splint. Treatment of fractures of the posterior pelvic ring is more complex and intense than a femoral head fracture or distal radius fracture because immobilization is difficult to maintain, justifying similar work values despite less intra-service time. **The RUC recommends a work RVU of 5.50 for CPT code 271X1.**

271X2 ***Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)***

The RUC reviewed the survey results from 56 orthopaedic surgeons and recommends the following physician time components: pre-service time of 58 minutes, intra-service time of 30 minutes, immediate post-service time of 25 minutes, and appropriate postoperative hospital and office visits. Pre-service package 4 (difficult patient/difficult procedure) was selected, with a reduction in scrub, dress, and wait time to be consistent with the survey median time for this activity.

The RUC reviewed the survey 25th percentile of 9.00 work RVUs, with total time of 293 minutes and determined it appropriately accounts for the physician work required to perform this service. The RUC compared the service to key reference services CPT code 20690, *Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system* (work RVU = 8.78, total time of 171 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, total time of 169 minutes) and noted that the two codes have less total time than the surveyed code, however the intensity and complexity of 271X2 is significantly greater justifying the greater work value. The RUC also compared 271X2 to MPC codes 50590, *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77, total time of 207 minutes) and 47562, *Laparoscopy, surgical; cholecystectomy* (work RVU=10.47, total time of 228 minutes) and agreed that these codes appropriately bracket the recommendation for 271X2, adding further support for the 25th percentile work RVU. **The RUC recommends a work RVU of 9.00 for CPT code 271X2.**

Practice Expense

The RUC reviewed and approved the direct practice expense inputs without modification as submitted by the specialty society and approved by the PE Subcommittee. The specialty discounted the 60 minutes of pre-service clinical staff time standard for 090 day globals to 20 minutes, in line with the recommendation for emergent procedures discussed by the PE Subcommittee at this meeting.

Work Neutrality

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

Bunionectomy (Tab 8)
Peter Mangone MD (AOFAS); Timothy Tillo DPM (APMA); William Creevy MD (AAOS); John Heiner MD (AAOS)

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 were necessary, including deletion of code(s), possible bundling of codes, and general descriptor revisions. In October 2015, the CPT Editorial Panel created two new codes (283X1, 282X2), deleted codes 28290, 28293, 28294 and revised 28289, 28292, 28296, 28297, 28298 and 28299 for more accurate description of the services as they are currently performed.

28289 ***Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant***
After consideration of the preliminary RUC reviewer comments, the specialty society revised their recommendation to the survey 25th percentile. The RUC reviewed the survey responses from 76 orthopaedic surgeons and podiatrists and determined that the survey 25th percentile work RVU of 6.90 appropriately accounts for the work required to perform this service. The RUC agreed with pre-service time of 53 minutes, intra-service time of 45 minutes and immediate post-operative time of 15 minutes. The RUC noted that the pre-service time is appropriate for this service and comparable to other similar services, for example CPT code 20240 *Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur).* The RUC agreed that a half-day 99238, 2-99212 and 2-99213 visits are appropriate to remove splints/dressings, assess surgical wound, remove sutures, assess circulation, sensation and motor function, redress wound and order physical therapy. The RUC compared the surveyed code to key reference services 28122 *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus* (work RVU = 6.76 and intra-service time of 45 minutes) and 28120 *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus* (work RVU = 7.31 and intra-service time of 50 minutes) and determined the physician work and time required to perform 28289 appropriately falls in between these two similar services. **The RUC recommends a work RVU of 6.90 for CPT code 28289.**

282X1 ***Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant***
After consideration of the preliminary RUC reviewer comments, the specialty society revised their recommendation to the survey 25th percentile. The RUC reviewed the survey responses from 37 orthopaedic surgeons and podiatrists and determined that the survey 25th percentile work RVU of 8.01 appropriately accounts for the work required to perform this service. The RUC agreed with pre-service time of 53 minutes, intra-service time of 50 minutes and immediate post-operative time of 15 minutes. The RUC noted that the pre-service time is appropriate for this service and comparable to other similar services, for example CPT code 20240 *Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur).* The RUC agreed that a half-day 99238, 2-99212 and 2-99213 visits are appropriate to remove splints/dressings, assess surgical wound, remove sutures, assess circulation, sensation and motor function, redress wound and order physical therapy. The RUC noted that this

service is appropriately more work than CPT code 28289. CPT code 28289 procedure is a clean up arthroplasty of osteophytes at joint on a degenerative joint. Whereas, this service is a total joint replacement and includes the work of 28289 with the addition of placement of the total joint including resection of both sides of the joint. The RUC compared the surveyed code to key reference services 28645 *Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed* (work RVU = 7.44 and intra-service time of 45 minutes) and 28750 *Arthrodesis, great toe; metatarsophalangeal joint* (work RVU = 8.57and intra-service time of 75 minutes) and determined the physician work and time required to perform 282X1 appropriately falls in between these two similar services. **The RUC recommends a work RVU of 8.01 for CPT code 282X1.**

28292 ***Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method***
After consideration of the preliminary RUC reviewer comments, the specialty society revised their recommendation to the survey 25th percentile. The RUC reviewed the survey responses from 57 orthopaedic surgeons and podiatrists and determined that the survey 25th percentile work RVU of 7.44 appropriately accounts for the work required to perform this service. The RUC agreed with pre-service time of 53 minutes, intra-service time of 45 minutes and immediate post-operative time of 15 minutes. The RUC noted that the pre-service time is appropriate for this service and comparable to other similar services, for example CPT code 20240 *Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur).* The RUC agreed that a half-day 99238, 3-99212 and 2-99213 visits are appropriate. This service is an osteotomy, which requires more work involving the healing at the joint from a soft tissue stand point and healing of the osteotomy and maintenance of the alignment. The additional office visit is required to assess x-rays for healing, motion and strength at the joint as well as mobility of the patient. Osteotomies require 6-8 weeks to heal and the physician must confirm prior to discharge. The RUC compared the surveyed code to key reference services 28645 *Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed* (work RVU = 7.44 and intra-service time of 45 minutes) and determined the physician work and time required to perform 28292 is the same as reference service code 28645. For additional support, the RUC compared the surveyed code 28750 *Arthrodesis, great toe; metatarsophalangeal joint* (work RVU = 8.57and intra-service time of 75 minutes) **The RUC recommends a work RVU of 7.44 for CPT code 28292.**

28296 ***Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method***
After consideration of the preliminary RUC reviewer comments, the specialty society revised their recommendation to the survey 25th percentile. The RUC reviewed the survey responses from 73 orthopaedic surgeons and podiatrists and determined that the survey 25th percentile work RVU of 8.25 appropriately accounts for the work required to perform this service. The RUC agreed with pre-service time of 53 minutes, intra-service time of 60 minutes and immediate post-operative time of 15 minutes. The RUC noted that the pre-service time is appropriate for this service and comparable to other similar services, for example CPT code 20240 *Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur).*The RUC agreed that a half-day 99238, 3-99212 and 2-99213 visits are appropriate. This service includes an osteotomy which requires more work involving the healing at the joint from a soft tissue stand point and healing of the osteotomy and maintenance of the alignment. The additional office visit is required to assess x-rays for healing, motion and strength at the joint as well as mobility of the patient. Osteotomies require 6-8 weeks to heal and the physician must confirm prior to discharge. The RUC compared the surveyed code to key reference services 28645 *Open treatment of metatarsophalangeal joint dislocation,*

includes internal fixation, when performed (work RVU = 7.44 and intra-service time of 45 minutes) and 28750 *Arthrodesis, great toe; metatarsophalangeal joint* (work RVU = 8.57and intra-service time of 75 minutes) and determined the physician work and time required to perform 28296 appropriately falls in between these two similar services. **The RUC recommends a work RVU of 8.25 for CPT code 28296.**

282X2 ***Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method***
After consideration of the preliminary RUC reviewer comments, the specialty society revised their recommendation to the survey 25th percentile. The RUC reviewed the survey responses from 67 orthopaedic surgeons and podiatrists and determined that the survey 25th percentile work RVU of 8.57 appropriately accounts for the work required to perform this service. The RUC agreed with pre-service time of 53 minutes, intra-service time of 60 minutes and immediate post-operative time of 15 minutes. The RUC noted that the pre-service time is appropriate for this service and comparable to other similar services, for example CPT code 20240 *Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur).*The RUC agreed that a half-day 99238, 3-99212 and 2-99213 visits are appropriate. This service includes an osteotomy which requires more work involving the healing at the joint from a soft tissue stand point and healing of the osteotomy and maintenance of the alignment. The additional office visit is required to assess x-rays for healing, motion and strength at the joint as well as mobility of the patient. Osteotomies require 6-8 weeks to heal and the physician must confirm prior to discharge. The RUC compared the surveyed code to key reference services 28750 *Arthrodesis, great toe; metatarsophalangeal joint* (work RVU = 8.57and intra-service time of 75 minutes) and determined the physician work to perform 282X2 is the same as key reference code 28750. For additional support, the RUC compared the surveyed code to 28740 *Arthrodesis, midtarsal or tarsometatarsal, single joint* (work RVU = 9.29 and intra-service time of 80 minutes). The specialty societies indicated and the RUC agreed that this service is more intense than 28296. CPT code 28296 is a metatarsal neck osteotomy and is already exposed at that level and has been operated on. With this service the physician must move the dissection back at the base of the metatarsal, which is harder and contains more cortical bones, which are more difficult to heal. **The RUC recommends a work RVU of 8.57 for CPT code 282X2.**

28297 ***Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method***
After consideration of the preliminary RUC reviewer comments, the specialty society revised their recommendation to the survey 25th percentile. The RUC reviewed the survey responses from 65 orthopaedic surgeons and podiatrists and determined that the survey 25th percentile work RVU of 9.29 appropriately accounts for the work required to perform this service. The RUC agreed with pre-service time of 53 minutes, intra-service time of 75 minutes and immediate post-operative time of 15 minutes. The RUC noted that the pre-service time is appropriate for this service and comparable to other similar services, for example CPT code 20240 *Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur).* The RUC agreed that a half-day 99238, 3-99212 and 2-99213 visits are appropriate. This service includes an osteotomy which requires more work involving the healing at the joint from a soft tissue stand point and healing of the osteotomy and maintenance of the alignment. The additional office visit is required to assess x-rays for healing, motion and strength at the joint as well as mobility of the patient. Osteotomies require 6-8 weeks to heal and the physician must confirm prior to discharge. The RUC compared the surveyed code to key reference services 28740 *Arthrodesis, midtarsal or tarsometatarsal, single joint* (work RVU = 9.29 and intra-service time of 80 minutes) and determined the physician work to

perform 28297 is the same as key reference code 28740 and requires similar intensity and complexity to perform. For additional support, the RUC compared the surveyed code to 27814 *Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed* (work RVU = 10.62 and intra-service time of 90 minutes) **The RUC recommends a work RVU of 9.29 for CPT code 28297.**

28298 *Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method*
After consideration of the preliminary RUC reviewer comments, the specialty society revised their recommendation to the survey 25th percentile. The RUC reviewed the survey responses from 73 orthopaedic surgeons and podiatrists and determined that the survey 25th percentile work RVU of 7.75 appropriately accounts for the work required to perform this service. The RUC agreed with pre-service time of 53 minutes, intra-service time of 60 minutes and immediate post-operative time of 15 minutes. The RUC noted that the pre-service time is appropriate for this service and comparable to other similar services, for example CPT code 20240 *Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur).* The RUC agreed that a half-day 99238, 2-99212 and 2-99213 visits are appropriate. The RUC compared the surveyed code to key reference services 28645 *Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed* (work RVU = 7.44 and intra-service time of 45 minutes) and 28750 *Arthrodesis, great toe; metatarsophalangeal joint* (work RVU = 8.57 and intra-service time of 75 minutes) and determined the physician work and time required to perform 28298 appropriately falls in between these two similar services. **The RUC recommends a work RVU of 7.75 for CPT code 28298.**

28299 *Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method*
After consideration of the preliminary RUC reviewer comments, the specialty society revised their recommendation to the survey 25th percentile. The RUC reviewed the survey responses from 65 orthopaedic surgeons and podiatrists and determined that the survey 25th percentile work RVU of 9.29 appropriately accounts for the work required to perform this service. The RUC agreed with pre-service time of 53 minutes, intra-service time of 75 minutes and immediate post-operative time of 15 minutes. The RUC noted that the pre-service time is appropriate for this service and comparable to other similar services, for example CPT code 20240 *Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur).* The RUC agreed that a half-day 99238, 3-99212 and 2-99213 visits are appropriate. This service includes an osteotomy which requires more work involving the healing at the joint from a soft tissue stand point and healing of the osteotomy and maintenance of the alignment. The additional office visit is required to assess x-rays for healing, motion and strength at the joint as well as mobility of the patient. Osteotomies require 6-8 weeks to heal and the physician must confirm prior to discharge. The RUC compared the surveyed code to key reference services 28750 *Arthrodesis, great toe; metatarsophalangeal joint* (work RVU = 8.57 and intra-service time of 75 minutes) and 27814 *Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed* (work RVU = 10.62 and intra-service time of 90 minutes) and determined the physician work and time required to perform 28299 appropriately falls in between these two similar services. The RUC also noted that 28299 requires the same work and intensity and complexity as 28297 (recommended above) and 28740 *Arthrodesis, midtarsal or tarsometatarsal, single joint* (work RVU = 9.29 and

intra-service time of 80 minutes). **The RUC recommends a work RVU of 9.29 for CPT code 28299.**

Practice Expense
The Practice Expense Subcommittee made minor modifications and reduced the number of scalpels, ace wraps and the equipment minutes. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

Laryngoplasty (Tab 9)
Peter Manes, MD (AAO-HNS); Mark Courey, MD (AAO-HNS); Lawrence Simon, MD (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, 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. The RUC agreed with the specialty to refer this code set back to CPT for revisions. At the October 2015 CPT Editorial Panel meeting, the Panel approved the creation of six new codes, revision of three codes and deletion of three codes.

Adult Laryngoplasty Procedures

31580 ***Laryngoplasty; for laryngeal web, with indwelling keel or stent insertion***
The RUC reviewed the survey results from 57 practicing otolaryngologists and agreed with the specialty society on the following time components: pre-service time of 58 minutes, intra-service time of 120 minutes and immediate post-service time of 30 minutes. The RUC also recommends the following post-operative visits: one 99291, one 99231, one 99238 and three 99213 office visits. The specialty society explained that the otolaryngologists work involved in the critical care visits is truly critical care work and not simply checking post-surgical wounds. During this time, the otolaryngologist and the intensivist are adjusting ventilator settings, titrating sedation and evaluating multiple points of radiologic and laboratory data.

The RUC reviewed the survey respondents' physician work values and agreed with the specialty society that the survey 25th percentile work RVU of 14.60 is appropriate for CPT code 31580. To justify a work RVU of 14.60, the RUC compared the survey code to MPC

code 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU= 14.56, intra time= 120 minutes) and noted that with identical intra-service time and comparable work, the surveyed code should be valued similar to this reference code. The RUC also reviewed CPT code 21048 *Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion[s])* (work RVU= 14.71, intra time= 120 minutes) and also agreed that this reference code validated the recommended work RVU of 14.60. **The RUC recommends a work RVU of 14.60 for CPT code 31580.**

315X2 ***Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older***
The RUC reviewed the survey results from 53 practicing otolaryngologists and agreed with the specialty society on the following time components: pre-service time of 58 minutes, intra-service time of 180 minutes and immediate post-service time of 30 minutes. The RUC also recommends the following post-operative visits: one 99291, one 99231, one 99232, one 99238 and three 99213 office visits. The specialty society explained that the otolaryngologists work involved in the critical care visits is truly critical care work and not simply checking post-surgical wounds. During this time, the otolaryngologist and the intensivist are adjusting ventilator settings, titrating sedation and evaluating multiple points of radiologic and laboratory data.

The RUC reviewed the survey respondents' physician work values and agreed with the specialty society that the survey median work RVU of 20.50 is appropriate for CPT code 3158X2. To justify a work RVU of 20.50, the RUC compared the survey code to the top two key reference services: 60252 *Thyroidectomy, total or subtotal for malignancy; with limited neck dissection* (work RVU= 22.01, intra time= 180 minutes) and 42420 *Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve* (work RVU 19.53, intra time= 180 minutes) and agreed that with identical intra-service time and comparable physician work, the recommedned value of 20.50 appropraitely fits in between these two services. Finally, the RUC noted that the while the intra-service time is being reduced from 210 mintues to 180 minutes, the work value is currently 23.22 and is seeing a similar reduction as well. **The RUC recommends a work RVU of 20.50 for CPT code 315X2.**

315X4 ***Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older***
The RUC reviewed the survey results from 52 practicing otolaryngologists and agreed with the specialty society on the following time components: pre-service time of 58 minutes, intra-service time of 195 minutes and immediate post-service time of 30 minutes. The RUC also recommends the following post-operative visits: one 99291, two 99231s, one 99232, one 99238 and three 99213 office visits. The specialty society explained that the otolaryngologists work involved in the critical care visits is truly critical care work and not simply checking post-surgical wounds. During this time, the otolaryngologist and the intensivist are adjusting ventilator settings, titrating sedation and evaluating multiple points of radiologic and laboratory data.

The RUC reviewed the survey respondents' physician work values and agreed with the specialty society that the survey median work RVU of 22.00 is appropriate for CPT code 315X4. To justify a work RVU of 22.00, the RUC compared the survey code to MPC code 50546 *Laparoscopy, surgical; nephrectomy, including partial ureterectomy* (work RVU=

21.87, intra time= 205 minutes) and noted that while the reference code has slightly more intra-service time, code 315X4 has more total time, 540 minutes compared to 466.5 minutes, and is accurately values slightly higher. Finally, the RUC made two observations. First, the recommended work RVU of 22.00 accurately places this service higher than 315X2, which accounts for the additional 15 minutes of intra-service time. Second, the RUC noted that while the survey intra-service time drops from 210 to 195, the recommended work RVU is less than the current work value of 23.22. **The RUC recommends a work RVU of 22.00 for CPT code 315X4.**

31584 Laryngoplasty; with open reduction and fixation (eg, plating) of fracture, includes tracheostomy, if performed

The RUC reviewed the survey results from 68 practicing otolaryngologists and agreed with the specialty society on the following time components: pre-service time of 58 minutes, intra-service time of 120 minutes and immediate post-service time of 30 minutes. The RUC also recommends the following post-operative visits: one 99291, one 99231, one 99232, one 99238 and three 99213 office visits. The specialty society explained that the otolaryngologists work involved in the critical care visits is truly critical care work and not simply checking post-surgical wounds. During this time, the otolaryngologist and the intensivist are adjusting ventilator settings, titrating sedation and evaluating multiple points of radiologic and laboratory data.

The RUC reviewed the survey respondents' physician work values and agreed that the survey median work RVU of 20.00 is appropriate for CPT code 31584. To justify a work RVU of 20.00, the RUC compared the survey code to several reference codes, including: 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU= 21.16, intra time= 120 minutes) and 24160 *Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components* (work RVU= 18.63, intra time= 120 minutes) and agreed that these services offer appropriate work RVU brackets around the recommended work value. **The RUC recommends a work RVU of 20.00 for CPT code 31584.**

315X5 Laryngoplasty, medialization; unilateral

The RUC reviewed the survey results from 78 practicing otolaryngologists and agreed with the specialty society on the following time components: pre-service time of 39 minutes, intra-service time of 120 minutes and immediate post-service time of 28 minutes. The RUC also recommends the following post-operative visits: a half-day discharge 99238 and three 99213 office visits.

The RUC reviewed the survey respondents' physician work values and agreed that the respondents overestimated the physician work involved at the median level (work RVU= 17.20). To arrive at an appropriate value, the RUC compared the surveyed code to CPT code 58544 *Laparoscopy, surgical, supracervical hysterectomy* (work RVU= 15.60, intra time= 120 minutes) and noted that both services have identical intra-service time and comparable physician work and intensity. Therefore, the RUC agreed that CPT code 315X5 should be directly crosswalked to code 58544. To justify a work RVU of 15.60, the RUC reviewed MPC codes 60500 P*arathyroidectomy or exploration of parathyroid(s)* (work RVU= 15.60, intra time= 120 minutes) and 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)* (work RVU= 17.31, intra time= 120 minutes) and agreed that both these reference codes provide appropriate magnitude estimation to justify the recommended work value of 15.60. **The RUC recommends a work RVU of 15.60 for CPT code 315X5.**

Pediatric Laryngoplasty Procedures

315X1 ***Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age***
The RUC reviewed the survey results from 31 practicing otolaryngologists and agreed with the specialty society on the following time components: pre-service time of 58 minutes, intra-service time of 180 minutes and immediate post-service time of 33 minutes. The RUC also recommends the following post-operative visits: one 99291, three 99231s, one 99232, two 99233s, one 99238 and three 99213 office visits. The specialty society noted that while the survey respondents indicated that there were three critical care visits in the post-operative period, to ensure there is no duplication of work there should only be one critical care visit included. The other two visits were shifted over to be hospital visits (99233s). The specialty again reiterated that the otolaryngologist is heavily involved in the critical care of these pediatric patients as well. During this time, the otolaryngologist and the intensivist are adjusting ventilator settings, titrating sedation and evaluating multiple points of radiologic and laboratory data.

The RUC reviewed the survey respondents' physician work values and agreed that the survey median work RVU of 21.50 is appropriate for CPT code 315X1. To justify a work RVU of 21.50, the RUC compared the survey code to the top key reference code 60252 *Thyroidectomy, total or subtotal for malignancy; with limited neck dissection* (work RVU= 22.01, intra time= 180 minutes) and note that since both codes have identical intra-service time and comparable physician work, the recommended value of 21.50 is appropriate. Furthermore, the RUC compared this pediatric code to the adult code with identical intra-service time (315X2, RUC recommended work RVU= 20.50) and agreed that 315X1 is appropriately valued higher due to greater total time and intensity of the procedure. **The RUC recommends a work RVU of 21.50 for CPT code 315X1.**

315X3 ***Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, younger than 12 years of age***
The RUC reviewed the survey results from 31 practicing otolaryngologists and agreed with the specialty society on the following time components: pre-service time of 58 minutes, intra-service time of 180 minutes and immediate post-service time of 33 minutes. The RUC also recommends the following post-operative visits: one 99291, four 99232s, two 99233s, one 99238 and three 99213 office visits. The specialty society noted that while the survey respondents indicated that there were three critical care visits in the post-operative period, to ensure there is no duplication of work there should only be one critical care visit included. The other two visits were shifted over to be hospital visits (99233s). The specialty again reiterated that the otolaryngologist is heavily involved in the critical care of these pediatric patients as well. During this time, the otolaryngologist and the intensivist are adjusting ventilator settings, titrating sedation and evaluating multiple points of radiologic and laboratory data.

The RUC reviewed the survey respondents' physician work values and agreed that the survey median work RVU of 22.00 is appropriate for CPT code 315X3. To justify a work RVU of 22.00, the RUC compared the survey code to the two key reference codes: 21558 *Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; 5 cm or greater* (work RVU= 21.58, intra time= 160 minutes) and 60252 *Thyroidectomy, total or subtotal for malignancy; with limited neck dissection* (work RVU= 22.01, intra time= 180 minutes) and agreed that these services, with comparable physician work, and similar intra-service times, appropriately place the recommended value between these two reference codes. The RUC also

compared this service to code 315X1 and noted that this value appropriate accounts for the additional work of placing the stent, which is included in the descriptor of 315X3. **The RUC recommends a work RVU of 22.00 for CPT code 315X3.**

31587 ***Laryngoplasty, cricoid split, without graft placement***
The RUC reviewed the survey results from 34 practicing otolaryngologists and agreed with the specialty society on the following time components: pre-service time of 58 minutes, intra-service time of 95 minutes and immediate post-service time of 30 minutes. The RUC also recommends the following post-operative visits: three 99231s, one 99232, one 99233, one 99238 and three 99213 office visits. The specialty society noted that while the survey respondents indicated that there were four critical care visits in the post-operative period, the specialty indicated that for this procedure there is no critical care. However, the RUC agreed that one of those critical care visits should be moved to a hospital level three visit (99233).

The RUC reviewed the survey respondents' physician work values and agreed with the specialty society that the respondents overestimated the physician work involved at the survey 25th percentile (work RVU= 15.70). Considering that no compelling evidence exists at this time to increase the value of this procedure, the RUC agreed that the current work RVU of 15.27 is appropriate. To justify a work RVU of 15.27, the RUC compared the surveyed code to the second key reference code 60500 *Parathyroidectomy or exploration of parathyroid(s)* (work RVU= 16.50, intra time= 120 minutes) and noted that since the reference code has more intra-service time, it is appropriately valued higher than 31587. The RUC also reviewed CPT code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (work RVU= 15.37, intra time= 90 minutes) and agreed that since this procedure has similar intra-service time and comparable post-operative follow-up care to the surveyed code, the two services should be valued similarly. **The RUC recommends a work RVU of 15.27 for CPT code 31587.**

315X6 ***Cricotracheal resection***
Prior to discussing the value for this code, the RUC received compelling evidence from the specialty society that the current work RVU for this procedure may be misvalued. Specifically, the current code used to report this service, CPT code 31582 *Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy* (work RVU= 23.22) is an inadequate clinical comparison of physician work to 315X6. Therefore, the current vignette for 31582 is flawed in that it describes a "2-year-old child who has anterior subglottic stenosis (70%). Surgical correction is accomplished with an autogenous costal cartilage graft. An Aboulker stent is also utilized," which does not represent the typical patient under the new code descriptor.

The RUC agreed that given the information above, there is compelling evidence that the current work RVU for 315X6 may be misvalued.

The RUC reviewed the survey results from 47 practicing otolaryngologists and agreed with the specialty society on the following time components: pre-service time of 58 minutes, intra-service time of 240 minutes and immediate post-service time of 33 minutes. The RUC also recommends the following post-operative visits: one 99291, three 99232s, two 99233s, one 99238 and three 99213 office visits. The specialty society noted that while the survey respondents indicated that there were three critical care visits in the post-operative period, to ensure there is no duplication of work there should only be one critical care visit included. The other two visits were shifted over to be hospital visits (99233s). The specialty again

reiterated that the otolaryngologist is heavily involved in the critical care of these pediatric patients as well. During this time, the otolaryngologist and the intensivist are adjusting ventilator settings, titrating sedation and evaluating multiple points of radiologic and laboratory data.

The RUC reviewed the survey respondents' physician work values and agreed that the survey median (work RVU= 25.00) is appropriate for CPT code 315X6. To justify a work RVU of 25.00, the RUC compared the surveyed code to the top key reference code 60252 *Thyroidectomy, total or subtotal for malignancy; with limited neck dissection* (work RVU= 22.01, intra time= 180 minutes) and agreed that since the survyed code has more intra-service time and more post-operative follow-up care, the recommended value is appropriately higher than the reference code. The RUC also reviewed CPT code 43336 *Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis* (work RVU= 25.81, intra time= 240 minutes) and agreed that since both codes have identical intra-service time and similar post-operative visits, the values should also be similar. Finally, the RUC noted that the survey intra-service time of 240 minutes is an increase of 30 minutes over the current reporting of this services, CPT code 31582 (work RVU= 23.22). Therefore, the recommended work RVU of 25.00 represents a reaonsable increase over this procedure, which has less physician work. **The RUC recommends a work RVU of 25.00 for CPT code 315X6.**

Practice Expense
The RUC reviewed and approved the modifications as established by the Practice Expense Subcommittee

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

Closure Left Atrial Appendage with Endocardial Implant (Tab 10)
Richard Wright, MD (ACC); Cliff Kavinsky, MD, PhD (SCAI); Mark Schoenfeld, MD (HRS); Thad Waites, MD (ACC); David Slotwiner, MD (HRS)

At the October 2015 CPT Editorial Panel meeting, the Panel deleted category III code 0281T and created CPT code 333X3 to describe Percutaneous transcatheter closure of the left atrial appendage with implant.

The RUC reviewed the survey results from 53 practicing cardiologists and agreed with the specialty societies on the following time components: pre-service time of 63 minutes, intra-service time of 90 minutes and immediate post-service time of 30 minutes.

The RUC reviewed the survey respondents' physician work values and agreed that the respondents overestimated the physician work involved at the survey 25th percentile (work RVU= 19.88). To determine an appropriate work value, the RUC compared the surveyed code to CPT code 93583 *Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed* (work RVU= 14.00, intra time= 90 minutes) and agreed that this value, with identical intra-service time, accurately accounted for the physician work involved in the surveyed code. Therefore, the RUC recommends a direct physician work crosswalk from CPT code 93583 to CPT code 333X3. To justify a work RVU of 14.00, the RUC reviewed CPT code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural*

roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation (work RVU= 14.00, intra time= 90 minutes). **The RUC recommends a work RVU of 14.00 for CPT code 333X3.**

Practice Expense
The RUC reviewed and accepted the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

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

Valvuloplasty (Tab 11)
James M. Levett, MD (STS); Kirk R. Kanter, MD (STS)

At the May 2015 CPT Editorial Panel meeting, the Panel restructured the valvuloplasty family and added two new codes 334X1 and 334X2 to better describe aortic valve repairs, which, under the current codes, are not accurately defined.

334X1 ***Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (ie, valvotomy, debridement, debulking and/or simple commissural resuspension)***
The RUC reviewed the survey results from 41 thoracic surgeons and agreed with the following physician time components: pre-service time of 95 minutes, intra-service time of 180 minutes and immediate post-service time of 45 minutes. The RUC also recommends the following post-operative visits: one 99291, one 99231, two 99232s, one 99233, one 99238, one 99212 and one 99213. The RUC agreed that there is 20 additional minutes for evaluation above the standard pre-service time package to account for the time the surgeon spends with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure including the additional complexity associated with an aortic valve repair. Extensive planning and review is required to identify the extent and type of repair required for the valve. In addition, the surgeon must take time to explain all of the elements usually discussed with standard aortic valve replacement should attempts at repairing the patient's own aortic valve fail and the reasons/implications of valve repair failure. The RUC also agreed to add 12 minutes of positioning time above the standard for this cardiac procedure, which is supported by many recently reviewed cardiothoracic procedures (e.g. codes 33405 and 33533).

The RUC reviewed the survey respondents' physician work values and agreed that the survey results overestimate the physician work RVUs, with a 25th percentile work RVU of 40.00. The current work RVU for this procedure is 41.50; however the valuation includes the work of both a simple and a complex procedure. To determine an appropriate value, the RUC compared the surveyed code to CPT code 33315 *Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); with cardiopulmonary bypass* (work RVU= 35.00, intra time= 180 minutes) and agreed that since both codes have identical intra-service time and comparable physician work, the two codes should be valued the same. Therefore, the RUC recommends a direct work RVU crosswalk of 35.00 from CPT code 33315 to CPT code 334X1. To justify a work RVU of 35.00, the RUC reviewed both the top two reference codes 33405 *Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve* (work RVU= 41.32, intra time= 197 minutes) and 33710 *Repair sinus of Valsalva fistula, with cardiopulmonary bypass; with repair of ventricular septal defect* (work RVU= 37.50, intra time= 200 minutes) and agreed that since both reference

services have more intra-service time than the surveyed code, the recommended value for 334X1 is appropriately valued less than these codes. **The RUC recommends a work RVU of 35.00 for CPT code 334X1.**

334X2 ***Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; complex (eg, leaflet extension, leaflet resection, leaflet reconstruction or annuloplasty)***
The RUC reviewed the survey results from 49 thoracic surgeons and agreed with the following physician time components: pre-service time of 95 minutes, intra-service time of 210 minutes and immediate post-service time of 45 minutes. The RUC also recommends the following post-operative visits: one 99291, one 99231, two 99232s, one 99233, one 99238, one 99213 and one 99214. The RUC agreed that there is 20 additional minutes for evaluation above the standard pre-service time package to account for the time the surgeon spends with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure including the additional complexity associated with an aortic valve repair. Extensive planning and review is required to identify the extent and type of repair required for the valve. In addition, the surgeon must take time to explain all of the elements usually discussed with standard aortic valve replacement should attempts at repairing the patient's own aortic valve fail and the reasons/implications of valve repair failure. In addition, the RUC also agreed to add 12 minutes of positioning time above the standard for this cardiac procedure, which is supported by many recently reviewed cardiothoracic procedures (e.g. codes 33405 and 33533).

Finally, the RUC determined a 99214 post-operative office visit is required for this procedure, whereas the simple code (334X1) has a 99213. This complex procedure requires more evaluations of the degree of residual valve disease. For the simple procedure, the post-operative care is more straightforward.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results accurately value this procedure at the 25th percentile work RVU of 44.00. To justify a work RVU of 44.00, the RUC compared the survey code to the top key reference code 33427 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring* (work RVU= 44.83, intra time= 221 minutes) and MPC codes 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring* (work RVU= 43.28, intra time= 205 minutes) and 33512 *Coronary artery bypass, vein only; 3 coronary venous grafts* (work RVU= 43.98, intra time= 213 minutes). The RUC determined that these three comparative codes provide appropriate brackets around the recommended value for 334X2. Finally, the RUC noted that while the total time for this procedure goes down slightly, from 742 minutes to 676 minutes, the previous valuation had three level three (99233) hospital visits. The time for the procedure has not changed. Also, the complex procedure, when it was last surveyed over 10 years ago, is not comparable to the procedure today, which has become more complex due to the change in patient population. **The RUC recommends a work RVU of 44.00 for CPT code 334X2.**

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

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

Partial Exchange Transfusion (Tab 12)
Steve Krug, MD, FAAP (AAP); Stephen Pearlman, MD, FAAP (AAP)

In May 2015, the CPT Editorial Panel established one new code to describe newborn partial exchange transfusion. At the October 2015 RUC meeting, while reviewing the specialty society's recommendation for new code 364X1, the RUC agreed that CPT codes 36440, 36450, 36455 and 36460 are also part of the same code family and should have been surveyed. The RUC also noted that CPT code 36450, a Harvard valued code, was placed on the reference service list for the RUC survey of 364X1 in error. Therefore, the RUC did not provide a recommendation for 364X1. The RUC requested that the specialty society survey codes 364X1, 36440, 36450, 36455 and 36460 for the January 2016 RUC meeting.

Compelling Evidence
The specialty societies presented compelling evidence for code 36450. The societies noted that the patient population for this service has changed since the code was originally developed. When first described, the procedure was very commonly performed on smaller pre-mature infants. This is no longer the case as the criteria for double volume exchange transfusion for hyperbilirubinemia has changed over the years, resulting in the typical patient being a relatively larger newborn. When the typical patient was smaller, the volume of blood that needed to be exchanged was smaller and the time for the exchange transfusion was shorter. In addition, the increased work RVU brings the value of this service more in line with the RUC recommended value for 364X1. The RUC agreed that there is compelling evidence that the service described by code 36450 was potentially misvalued.

364X1 ***Partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified health care professional, newborn***
The RUC reviewed the survey results from 47 pediatricians and agreed with the following physician time components: pre-service time of 15 minutes, intra-service time of 30 minutes, and post-service time of 15 minutes. The specialty noted that, during the intraservice period, the typical case may need the procedure to be stopped temporarily or slowed down due to a variety of issues such as instability of the patient, the vascular access not working properly, etc. The physician is at the bedside during this waiting time.

The RUC reviewed the survey 25th percentile work RVU of 2.00 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 2.00, the RUC 2nd key reference and MPC code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient* (work RVU= 2.00, intra-service time of 30 minutes, total time of 55 minutes) and noted that both services have identical intra-service times, similar total times and intensities, and therefore should be valued similarly. The RUC also reviewed CPT code 95939 *Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs* (work RVU= 2.25, intra-service time of 30 minutes, total time of 60 minutes) and noted that both services have identical intra-service times and total times, while the survey code has somewhat less intensity, further supporting a work RVU of 2.00 for the survey code. **The RUC recommends a work RVU of 2.00 for CPT code 364X1.**

36440 ***Push transfusion, blood, 2 years or younger***
The RUC reviewed the survey results from 41 pediatricians and agreed with the following physician time components: pre-service time of 10 minutes, intra-service time of 15 minutes, and post-service time of 10 minutes. The RUC noted that the existing physician time from the

Harvard study was not valid and that this service had never been evaluated by the RUC in the past.

The RUC reviewed the survey 25th percentile work RVU of 1.20 and agreed that the survey responds had somewhat overvalued the physician work involved in performing this service. The specialty society noted that there was no compelling evidence to support an increase in the work RVU of this service. The RUC compared the survey code to key reference and MPC code 94004 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day* (work RVU= 1.00, intra-service time of 15 minutes and total time of 35 minutes) and noted that both services have identical times, thought the survey code has somewhat more physician work intensity as per the survey intensity/complexity ratings, supporting maintaining the work RVU of the survey code at 1.03 RVUs. To further justify maintaining the current work RVU, the RUC compared the survey code to CPT code 95907 *Nerve conduction studies; 1-2 studies* (work RVU=1.00, intra-service time of 15 minutes, total time of 35 minutes) and noted that both services have identical physician times, while the survey code involves somewhat more physician intensity. **The RUC recommends a work RVU of 1.03 for CPT code 36440.**

36450 ***Exchange transfusion, blood; newborn***
The RUC reviewed the survey results from 44 pediatricians and agreed with the following physician time components: pre-service time of 30 minutes, intra-service time of 120 minutes, and post-service time of 30 minutes. The specialty society noted that this service is a double volume exchange transfusion. The specialty society noted that although the 364X1 procedure involves a sicker typical patient than code 36450, the double exchange involves substantially more physician time than the partial exchange code. The specialty society explained to the RUC that the typical patient has an estimated blood volume of 85 ml/kg and is 3.5 kg. The volume of blood needed for a double volume exchange for this patient is 595 ml. Typically; 15 ml is exchanged per pass, which will require 40 passes. The specialty society provided literature that supported each cycle taking 3 minutes. The RUC noted that this analysis supported the median intraservice time of 120 minutes. In addition, the RUC noted that the existing physician time from the Harvard study was not valid and had never been evaluated by the RUC in the past.

The RUC reviewed the survey median work RVU of 3.50 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 3.50, the RUC compared the survey code to CPT code 92523 *Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)* (work RVU=3.00, intra-service time of 120 minutes, total time of 157 minutes) and noted that both codes have identical intraservice times, while the survey code has much more total time and involves more intensity, supporting a higher work RVU for the survey code. The RUC also compared the survey code to CPT code 38230 *Bone marrow harvesting for transplantation; allogeneic* (work RVU=3.50, intra-service time of 90 minutes, total time of 175 minutes) and noted that both services have similar total times and involve a similar amount of total physician work, supporting a similar work RVU. **The RUC recommends a work RVU of 3.50 for CPT code 36450.**

36455 ***Exchange transfusion, blood; other than newborn***
The RUC reviewed the survey results from 77 pediatricians and agreed with the following physician time components: pre-service time of 30 minutes, intra-service time of 60 minutes, and post-service time of 30 minutes. The RUC noted that the existing physician time from the

Harvard study was not valid and that this service had never been evaluated by the RUC in the past.

The RUC reviewed the survey 25th percentile work RVU and agreed that the survey responds had somewhat overvalued the physician work involved in performing this service. The specialty society noted that there was no compelling evidence to support an increase in the work RVU of this service. The RUC compared the survey code to CPT code 91117 *Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report* (work RVU= 2.45, intra-service time of 60 minutes, total time of 105 minutes) and noted that both services have identical intra-service time and similar intensity, whereas the survey code has more total time, which supports maintaining the work RVU for the survey code at 2.43. To further justify a work RVU of 2.43, the RUC compared the survey code to CPT code 95872 *Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied* (work RVU= 2.88, intra-service time of 60 minutes) and noted that both services have identical intra-service times, though the reference code involves more intense physician work, supporting a lower work RVU for the survey code. **The RUC recommends a work RVU of 2.43 for CPT code 36455.**

36460 ***Transfusion, intrauterine, fetal***
For the January 2016 RUC meeting, the American Congress of Obstetricians and Gynecologists submitted a letter to the RUC noting that CPT code 36460, is not part of the same code family as CPT code 364X1 and the RUC agreed, noting this service is performed by a different provider and involves a different patient (mother not newborn). The RUC also noted that this service was only had a Medicare utilization of 10 in 2014. **The RUC agreed with the specialty society that this service is not part of the same code family as 364X1.**

Practice Expense
There are no direct practice expense inputs for CPT codes 364X1, 36440, 36450 and 36455. These services are facility-only and do not require any clinical staff pre-service time.

<u>Mechanochemical (MOCA) Vein Ablation (Tab 13)</u>
Matthew Sideman, MD (SVS); Robert Zwolak, MD (SVS); Michael Hall, MD (SIR); Jerry Niedzwiecki, MD (SIR); Mark Forrestal, MD (ACPh)

At the October 2015 CPT meeting, the CPT Editorial Panel established two Category I codes for reporting venous mechanochemical ablation.

36X41 ***Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated***
The RUC reviewed the survey results from 91 physicians and agreed with the following physician time components: pre-service time of 31minutes (standard pre-time package 6A with 3 minutes added to positioning and 5 minutes added to scrub/dress/wait), intra-service time of 30 minutes, and post-service time of 15 minutes (standard post-time package 7A minus 3 minutes).

The RUC reviewed the survey respondents' physician work values for CPT code 36X41 and agreed with the specialty that the survey respondents overvalued the work involved in performing this service. To determine an appropriate work value for 36X41, the RUC reviewed MPC code 52214 *Cystourethroscopy, with fulguration (including cryosurgery or*

laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands (work RVU= 3.50, intra-service time of 30 minutes, total time of 79 minutes) and noted that both services have identical intra-service time, as well as similar physician work and total time. Given these similarities, the RUC recommends a work RVU of 3.50, which is a direct crosswalk to CPT code 52214. To justify a work RVU of 3.50, the RUC reviewed CPT code 45380 *Colonoscopy, flexible; with biopsy, single or multiple* (work RVU= 3.66, intra-service time of 28 minutes, total time of 70 minutes) and noted that the survey code has more intra-service and total time, while also involving a similar amount of physician work. **The RUC recommends a work RVU of 3.50 for CPT code 36X41.**

364X2 ***Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 74 physicians and agreed with the following physician time components: intra-service time of 30 minutes.

The RUC reviewed the survey respondents' physician work values for CPT code 364X2 and agreed with the specialty that the survey respondents overvalued the work involved in performing this service. To determine an appropriate work value for 364X2, the RUC reviewed CPT code 49435 *Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site (List separately in addition to code for primary procedure)* (work RVU= 2.25, intra-service time of 30 minutes) and noted that both services have identical intra-service time and involve a similar amount of physician work. Given these similarities, the RUC recommends a work RVU of 2.25, which is a direct crosswalk to CPT code 49435. To justify a work RVU of 2.25, the RUC reviewed 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 both services have identical intra-service time and a similar amount of physician work. In addition, the RUC observed that, compared to the radiofrequency ablation (RFA) and endovascular laser treatment (EVLT) families of services, the total time ratio between the base code and add-on code for MOCA vein ablation is much smaller. This distinction supports a narrower RVU differential for the MOCA base code and add-on code, when compared to the larger gap between the RFA/EVLT base and add-on codes. **The RUC recommends a work RVU of 2.25 for CPT code 364X2.**

36475 ***Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated***
The RUC briefly discussed CPT code 36475, noting that it was last surveyed for the April 2014 RUC meeting. The RUC agreed that the existing RVU and times for this service are appropriate. **The RUC reaffirmed the work RVU of 5.30 for CPT code 36475.**

36476 ***Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)***
The RUC briefly discussed CPT code 36476, noting that it was last surveyed for the April 2014 RUC meeting. The RUC agreed that the existing RVU and times for this service are appropriate. **The RUC reaffirmed the work RVU of 2.65 for CPT code 36476.**

36478 ***Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated***
The RUC briefly discussed CPT code 36478, noting that it was last surveyed for the April 2014 RUC meeting. The RUC agreed that the existing RVU and times for this service are appropriate. **The RUC reaffirmed the work RVU of 5.30 for CPT code 36478.**

36479 ***Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)***
The RUC briefly discussed CPT code 36479, noting that it was last surveyed for the April 2014 RUC meeting. The RUC agreed that the existing RVU and times for this service are appropriate. **The RUC reaffirmed the work RVU of 2.65 for CPT code 36479.**

New Technology
CPT codes 36X41 and 364X2 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and specifically review utilization trends.

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

Dialysis Circuit (Tab 14)
Matthew Sideman, MD (SVS); Robert Zwolak, MD (SVS); Michael Hall, MD (SIR); Jerry Niedzwiecki, MD (SIR); Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); and Tim Pflederer, MD (RPA)

Facilitation Committee #2

In January 2015, the Joint CPT/RUC Workgroup on Codes Reported Together Frequently identified codes 35475, 35476, 36147, 36148, 37236, 37238, 75791, 75962, and 75968 as being frequently reported together in various combinations. At the October 2015 CPT Editorial Panel meeting, the Panel approved the creation of nine new codes and deletion of four codes to describe bundled dialysis circuit intervention services.

369X1 ***Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report***
The RUC reviewed the survey results from 114 interventional radiologists, nephrologists and vascular surgeons and agreed with the following physician time components: pre-service time of 26 minutes, intra-service time of 25 minutes and immediate post-service time of 15 minutes. The RUC agreed that 3 additional minutes above the standard pre-service time package is necessary because the procedure is performed on the extremity, typically the arm, with fluoroscopy. The arm needs to be appropriately placed and padded to allow imaging of the entire arm, access, and central venous drainage. In addition, the RUC added 5 minutes to the scrub, dress and wait time, as the pre-service time package does not allocate minutes for dressing and scrubbing for the procedure, only for administration of a local anesthetic. Sterile

operating room technique is maintained for this procedure when performed in an office procedure/surgery suite, requiring scrubbing and sterile gown, mask and gloves for the physician and clinical staff.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results overestimate the work involved in the service at the 25th percentile work RVU of 3.72. To determine an appropriate work RVU, the RUC compared the surveyed code to CPT code 45378 *Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (work RVU= 3.36, intra time= 25 minutes) and noted that both services have identical intra-service time and comparable physician work. Therefore, the RUC recommends a work RVU of 3.36, a direct work RVU crosswalk from code 45378, for CPT code 369X1. To justify a work RVU of 3.36, the RUC reviewed CPT codes 19083 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance* (work RVU= 3.10, intra time= 25 minutes) and 15277 *Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children* (work RVU= 4.00, intra time= 25 minutes) and agreed that these two services, with identical intra-service time and comparable work, provide accurate comparisons to the recommended value. **The RUC recommends a work RVU of 3.36 for CPT code 369X1.**

369X2 ***Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty*** The RUC reviewed the survey results from 114 interventional radiologists, nephrologists and vascular surgeons and agreed with the following physician time components: pre-service time of 26 minutes, intra-service time of 40 minutes and immediate post-service time of 20 minutes. The RUC agreed that 3 additional minutes above the standard pre-service time package is necessary because the procedure is performed on the extremity, typically the arm, with fluoroscopy. The arm needs to be appropriately placed and padded to allow imaging of the entire arm, access, and central venous drainage. In addition, the RUC added 5 minutes to the scrub, dress and wait time, as the pre-service time package does not allocate minutes for dressing and scrubbing for the procedure, only for administration of a local anesthetic. Sterile operating room technique is maintained for this procedure when performed in an office procedure/surgery suite, requiring scrubbing and sterile gown, mask and gloves for the physician and clinical staff.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results overestimate the work involved in the service at the 25th percentile work RVU of 6.00. To determine an appropriate work RVU, the RUC compared the surveyed code to CPT code 43253 *Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)* (work RVU= 4.83, intra time= 40 minutes) and noted that both services have identical intra-service time and comparable physician work.

Therefore, the RUC recommends a work RVU of 4.83, a direct work RVU crosswalk from code 43253, for CPT code 369X2. To justify a work RVU of 4.83, the RUC reviewed 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, intra time= 45 minutes) and CPT code 45393 *Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed* (work RVU= 4.78, intra time= 40 minutes) and agreed that these two services, with similar intra-service time and work, provide accurate comparisons to the recommended value. **The RUC recommends a work RVU of 4.83 for CPT code 369X2.**

369X3 ***Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s) peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment***
The RUC reviewed the survey results from 114 interventional radiologists, nephrologistsand vascular surgeons and agreed with the following physician time components: pre-service time of 26 minutes, intra-service time of 50 minutes and immediate post-service time of 20 minutes. The RUC agreed that 3 additional minutes above the standard pre-service time package is necessary because the procedure is performed on the extremity, typically the arm, with fluoroscopy. The arm needs to be appropriately placed and padded to allow imaging of the entire arm, access, and central venous drainage. In addition, the RUC added 5 minutes to the scrub, dress and wait time, as the pre-service time package does not allocate minutes for dressing and scrubbing for the procedure, only for administration of a local anesthetic. Sterile operating room technique is maintained for this procedure when performed in an office procedure/surgery suite, requiring scrubbing and sterile gown, mask and gloves for the physician and clinical staff.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results overestimate the work involved in the service at the 25th percentile work RVU of 8.00. To determine an appropriate work RVU, the RUC compared the surveyed code to CPT code 52282 *Cystourethroscopy, with insertion of permanent urethral stent* (work RVU= 6.39, intra time= 50 minutes) and noted that both services have identical intra-service time and comparable physician work. Therefore, the RUC recommends a work RVU of 6.39, a direct work RVU crosswalk from code 52282, for CPT code 369X3. To justify a work RVU of 6.39, the RUC reviewed CPT codes 36224 *Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed* (work RVU= 6.50, intra time= 50 minutes) and 93459 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography* (work RVU= 6.60, intra time= 50 minutes) and agreed that these two services, with identical intra-service time and comparable work, provide accurate comparisons to the recommended value. **The RUC recommends a work RVU of 6.39 for CPT code 369X3.**

369X4 ***Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)***
The RUC reviewed the survey results from 114 interventional radiologists, nephrologists and vascular surgeons and agreed with the following physician time components: pre-service time of 31 minutes, intra-service time of 60 minutes and immediate post-service time of 20 minutes. The RUC agreed that 3 additional minutes above the standard pre-service time package is necessary because the procedure is performed on the extremity, typically the arm, with fluoroscopy. The arm needs to be appropriately placed and padded to allow imaging of the entire arm, access, and central venous drainage. In addition, the RUC added 5 minutes to the scrub, dress and wait time, as the pre-service time package does not allocate minutes for dressing and scrubbing for the procedure, only for administration of a local anesthetic. Sterile operating room technique is maintained for this procedure when performed in an office procedure/surgery suite, requiring scrubbing and sterile gown, mask and gloves for the physician and clinical staff.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results accurately value this service at the 25th percentile work RVU of 7.50. To justify a work RVU of 7.50, the RUC compared the surveyed code to MPC code 52353*Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU= 7.50, intra time = 60 minutes) and agreed that since both services should be valued the same, given their identical intra-service times and comparable physician work. The RUC also reviewed CPT codes 39402 *Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)* (work RVU= 7.25, intra time= 60 minutes) and 37211 *Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day* (work RVU= 8.00, intra time= 60 minutes) and agreed that these two services, with identical intra-service time and comparable work, provide accurate comparisons to the recommended value. **The RUC recommends a work RVU of 7.50 for CPT code 369X4.**

369X5 ***Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty***
The RUC reviewed the survey results from 114 interventional radiologists, nephrologists and vascular surgeons and agreed with the following physician time components: pre-service time of 31 minutes, intra-service time of 75 minutes and immediate post-service time of 20 minutes. The RUC agreed that 3 additional minutes above the standard pre-service time package is necessary because the procedure is performed on the extremity, typically the arm, with fluoroscopy. The arm needs to be appropriately placed and padded to allow imaging of the entire arm, access, and central venous drainage. In addition, the RUC added 5 minutes to the scrub, dress and wait time, as the pre-service time package does not allocate minutes for dressing and scrubbing for the procedure, only for administration of a local anesthetic. Sterile operating room technique is maintained for this procedure when performed in an office procedure/surgery suite, requiring scrubbing and sterile gown, mask and gloves for the physician and clinical staff.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results accurately value this service at the 25th percentile work RVU of 9.00. To justify a work RVU of 9.00, the RUC compared the surveyed code to CPT codes 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty* (work RVU= 9.00, intra time= 80 minutes) and 43265 *Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)* (work RVU= 8.03, intra time= 78 minutes) and agreed that these two services, with comparable intra-service time and work, provide accurate comparisons to the recommended value. Finally, the RUC noted that code 389X5 has 15 additional minutes of intra-service time compared to 369X4, resulting in an appropriate increment of 1.50 work RVUs. **The RUC recommends a work RVU of 9.00 for CPT code 369X5.**

369X6 ***Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of an intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation to perform the stenting and all angioplasty within the peripheral dialysis circuit***

The RUC reviewed the survey results from 114 interventional radiologists, nephrologists and vascular surgeons and agreed with the following physician time components: pre-service time of 31 minutes, intra-service time of 90 minutes and immediate post-service time of 20 minutes. The RUC agreed that 3 additional minutes above the standard pre-service time package is necessary because the procedure is performed on the extremity, typically the arm, with fluoroscopy. The arm needs to be appropriately placed and padded to allow imaging of the entire arm, access, and central venous drainage. In addition, the RUC added 5 minutes to the scrub, dress and wait time, as the pre-service time package does not allocate minutes for dressing and scrubbing for the procedure, only for administration of a local anesthetic. Sterile operating room technique is maintained for this procedure when performed in an office procedure/surgery suite, requiring scrubbing and sterile gown, mask and gloves for the physician and clinical staff.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results accurately value this service at the 25th percentile work RVU of 10.42. To justify a work RVU of 10.42, the RUC compared the surveyed code to the second key reference code 37221 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 10.00, intra time= 90 minutes) and agreed that since both services have identical intra-service time, they should both be valued similarly. The RUC also reviewed CPT codes 61650 *Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory* (work RVU= 10.00, intra time= 90 minutes) and 37226 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 10.49, intra time= 90 minutes) and agreed that these two services, with comparable intra-service time and work, provide accurate comparisons to the recommended value. Finally, the RUC noted that code 379X6 has 15 additional minutes of intra-service time compared to 369X5, resulting in an appropriate increment of approximately 1.50 work RVUs that was established between 369X4 and 369X5. **The RUC recommends a work RVU of 10.42 for CPT code 369X6.**

369X7 ***Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 114 interventional radiologists, nephrologists and vascular surgeons and agreed that an intra-service time of 25 minutes is appropriate for this add-on procedure.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results overestimate the work involved in the service at the 25th percentile work RVU of 3.73. To determine an appropriate work RVU, the RUC compared the surveyed code to CPT code 32506 *Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral* (work RVU= 3.00, intra time= 25 minutes) and noted that both services have identical intra-service time and comparable physician work. Therefore, the RUC recommends a work RVU of 3.00, a direct work RVU crosswalk from code 32506, for CPT code 369X7. To justify a work RVU of 3.00, the RUC reviewed CPT code 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites* (work RVU= 2.65, intra time= 30 minutes) and 61782 *Stereotactic computer-assisted (navigational) procedure; cranial, extradural* (work RVU= 3.18, intra time= 25 minutes) and agreed that these two services, with similar intra-service time and work, provide accurate comparisons to the recommended value. **The RUC recommends a work RVU of 3.00 for CPT code 369X7.**

369X8 ***Transcatheter placement of an intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 114 interventional radiologists, nephrologist and vascular surgeons and agreed that an intra-service time of 40 minutes is appropriate for this add-on procedure.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results accurately value this service at the 25th percentile work RVU of 4.25. To justify a work RVU of 4.25, the RUC compared the surveyed code to the top key reference code 37223 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 4.25, intra time= 45 minutes) and noted that while the reference code has 5 additional minutes of intra-service time, 369X8 represents more intense work and is justifiably valued the same. The RUC also reviewed CPT code 37232 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty* (work RVU= 4.00, intra time= 40 minutes) and agreed that this service, with similar intra-service time and work, provide an accurate comparison to the recommended value. **The RUC recommends a work RVU of 4.25 for CPT code 369X8.**

369X9 ***Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 114 interventional radiologists, nephrologists and vascular surgeons and agreed that an intra-service time of 30 minutes is appropriate for this add-on procedure.

The RUC reviewed the survey respondents' physician work values and agreed that the survey 25th percentile work RVU of 4.25 is too high for this procedure. To determine an appropriate work value, the RUC compared the surveyed code to CPT code 38746 *Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy* (work RVU= 4.12, intra time= 30 minutes) and noted that both services have identical intra-service time and comparable physician work. Therefore, the RUC recommends a work RVU of 4.12, a direct work RVU crosswalk from code 38746, for CPT code 369X9. To justify a work RVU of 4.12, the RUC reviewed CPT codes 32674*Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy* (work RVU= 4.12, intra time= 30 minutes and 36228 *Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery)* (work RVU= 4.25, intra time= 30 minutes) and agreed that these two services, with identical intra-service time and work, provide accurate comparisons to the recommended value.

The RUC also compared this service to the similar transluminal balloon angioplasty service reviewed at this meeting, CPT code 372X4 (RUC recommended work RVU of 2.97). The RUC noted that while these two services have identical intra-service times, embolization of the fistula is a very different, more complex service than an angioplasty. CPT code 369X9 involves manipulating the catheter more frequently than an angioplasty. The physician is also depositing multiple coils and coil placement is important as the risk that the coil may travel centrally in to the pulmonary vasculature is high. Furthermore, the RUC noted that code 369X9 is the next step following the work of code 369X1 and therefore represents an appropriate increase above 369X1 (RUC recommended work RVU= 3.36, intra time= 25 minutes) given the 5 additional minutes of intra-service time. **The RUC recommends a work RVU of 4.12 for CPT code 369X9.**

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

<u>Open and Percutaneous Transluminal Angioplasty (Tab 15)</u>
Matthew Sideman, MD (SVS); Robert Zwolak, MD (SVS); Michael Hall, MD (SIR); Jerry Niedzwiecki, MD (SIR); Zeke Silva III, MD (SIR); Kurt Schoppe, MD (ACR)

In January 2015, the Joint CPT/RUC Workgroup on Codes Reported Together Frequently identified codes 35475, 35476, 36147, 36148, 37236, 37238, 75791, 75962, and 75968 as being frequently reported together in various combinations. At the October 2015 CPT Editorial Panel meeting, the Panel approved the creation of four new codes and deletion of 13 codes to describe bundled percutaneous transluminal angioplasty services.

372X1 ***Transluminal balloon angioplasty (except lower extremity artery(s) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery***
The RUC reviewed the survey results from 78 practicing radiologists, interventional radiologists and vascular surgeons and agreed with the following physician time components: pre-service time of 31 minutes, intra-service time of 60 minutes and immediate post-service time of 28 minutes. The RUC agreed to add 2 minutes of pre-service positioning time to the standard pre-service time package to assist with adjusting the imaging table and anesthesia lines to ensure the physician can obtain all the necessary views required for the intervention.

The RUC reviewed the survey respondents' physician work values and agreed that the survey 25th percentile work RVU of 7.00 is appropriate. To justify a work RVU of 7.00, the RUC compared the surveyed code to the second key reference code 37211 *Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day* (work RVU= 8.00, intra time= 60 minutes) and noted that while both codes have identical intra-service time, the reference code has greater total time, 138 minutes compared to 119 minutes, and is justifiably valued higher than 372X1. The RUC also reviewed MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU= 7.50, intra time= 60 minutes) and code 43264 *Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)* (work RVU= 6.73, intra time= 60 minutes) and agreed that both these services, with identical intra-service time and comparable physician work, the recommended value for 372X1 is relative to other similar services. **The RUC recommends a work RVU of 7.00 for CPT code 372X1.**

372X2 ***Transluminal balloon angioplasty (except lower extremity artery(s) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery***
The RUC reviewed the survey results from 78 practicing radiologists, interventional radiologists and vascular surgeons and agreed with the median intra-service time of 30 minutes for this add-on procedure.

The RUC reviewed the survey respondents' physician work values and agreed that the survey 25th percentile work RVU of 3.50 is appropriate. To justify a work RVU of 3.50, the RUC compared the surveyed code to CPT codes 22512 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body* (work RVU= 4.00, intra time= 30 minutes) and 61783 *Stereotactic computer-assisted (navigational) procedure; spinal* (work RVU= 3.75, intra time= 30 minutes) and agreed that both these services, with identical intra-service time and comparable physician work, the recommended value for 372X2 is relative to other similar services. Furthermore, this service represents half the intra-service time of the base procedure 372X1 and thus represents half the work value as well. **The RUC recommends a work RVU of 3.50 for CPT code 372X2.**

372X3 ***Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein***
Prior to valuing this procedure, the RUC discussed compelling evidence that the work RVUs associated with the current reporting of this procedure may be undervalued. The RUC did note however that due to the bundling of procedures with this entire family, significant redistribution is occurring. The specialty societies noted that there will be a change in patient population for this procedure. The utilization of the former venous angioplasty code 35476 will be dispersed between the new bundled codes for dialysis and the new bundled codes for angioplasty. Based on 2014 Medicare utilization data, approximately 81% of the 35475 claims were for hemodialysis related procedures. These patients will be captured in the new dialysis bundle codes while the remaining 19% represent a new patient population that is distinctly different from the previous code. These venous angioplasties will involve mainly central venous stenoses and represent more work at a higher intensity compared to a venous angioplasty in a dialysis access. Given this evidence, the RUC accepted compelling evidence for CPT code 372X3.

The RUC reviewed the survey results from 78 practicing radiologists, interventional radiologists and vascular surgeons and agreed with the following physician time components: pre-service time of 31 minutes, intra-service time of 60 minutes and immediate post-service time of 28 minutes. The RUC agreed to add 2 minutes of pre-service positioning time to the standard pre-service time package to assist with adjusting the imaging table and anesthesia lines to ensure the physician can obtain all the necessary views required for the intervention.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work RVU of 6.00 is appropriate. To justify a work RVU of 6.00, the RUC compared the surveyed code to the top two key reference codes 37238 *Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein* (work RVU= 6.29, intra time= 60 minutes) and 37212 *Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day* (work RVU=7.06, intra time= 60 minutes) and agreed that both these services, with identical intra-service time and comparable physician work, the recommended value for 372X3 is relative to other similar services. **The RUC recommends a work RVU of 6.00 for CPT code 372X3.**

372X4 ***Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein***
The RUC reviewed the survey results from 78 practicing radiologists, interventional radiologists and vascular surgeons and agreed with the median intra-service time of 30 minutes for this add-on procedure.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work RVU of 2.97 is appropriate. To justify a work RVU of 2.97, the RUC compared the surveyed code to the top key reference code 37239 *Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein* (work RVU= 2.97, intra time= 30 minutes) and agreed that this reference code, with identical intra-service time, should be valued the same as 372X4. In addition, the RUC reviewed CPT codes 22515 *Percutaneous vertebral augmentation,*

including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (work RVU= 4.00, intra time= 30 minutes) and 32668 *Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection* (work RVU= 3.00, intra time= 30 minutes) and agreed that both these services, with identical intra-service time and comparable physician work, the recommended value for 372X4 relative to other similar services. As was the case with the relationship between the arterial angioplasty base code and the associated add-on code, this venous angioplasty add-on code (372X4) represents half the intra-service time of the base code 372X3 and roughly half the work RVU. **The RUC recommends a work RVU of 2.97 for CPT code 372X4.**

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

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

Esophagectomy (Tab 16)
James Levett, MD, FACS (STS); Charles Mabry, MD, FACS (ACS); Donald Selzer, MD, FACS (SAGES)

In October 2015, the CPT Editorial Panel created three new codes 432X5, 432X6, 432X7 to report esophagectomy via laparoscopic and thoracoscopic approaches, and revised 43112 to clarify this service. However, during the CPT Panel minutes review the vignette was altered, removing the statement that the typical patient undergoes chemotherapy and radiation therapy prior to surgery. The specialties contacted the Panel and tried to correct prior to survey; however, the Panel did not adjust the vignette. The specialty societies conducted a survey and found that a significant number of respondents did not agree that the vignette described the typical patient and noted that the typical patient does undergo neoadjuvant chemotherapy and radiation therapy prior to surgery. Therefore, the survey is flawed and the codes should be re-surveyed with the appropriate vignette. **The RUC agrees with the specialty societies and recommends:**

1) **The CPT Editorial Panel table new codes 432X5, 432X6, 432X7 until CPT 2018;**
2) **The specialty societies go to the Research Subcommittee to obtain approval for the current typical patient (vignette) for both the new thoracoscopic/laparoscopic codes and open codes (43107, 43112 and 43117); and**
3) **The specialty societies survey all six codes for the October 2016 RUC meeting.**

Esophageal Sphincter Augmentation (Tab 17)
Donald Selzer, MD, FACS (SAGES); Francis Nichols, MD, FACS (STS); James Levett, MD, FACS (STS); Jay Gregory, MD (ASGS)

In October 2015, the CPT Editorial Panel created two new codes to describe laparoscopic implantation and removal of a magnetic bead sphincter augmentation device for treatment of gastroesophageal reflux disease (GERD).

With Research Subcommittee approval, the specialty societies utilized an industry provided provider list and conducted a targeted survey of the 145 physicians who have undergone training and are allowed to order the device for implantation and are the only physicians who have performed these procedures. Only 18 non-conflicted survey responses were received even after multiple communications following up with the 145 physicians.

432X1 ***Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed***
The specialty societies convened an expert panel and compared the survey median intra-service time for 432X1 (60 minutes) to the intra-service time for 49320 *Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (intra-service time = 45 minutes) and agreed with the survey respondents that 60 minutes appropriately accounts for the additional work of placing the magnetic bead device. The RUC agreed and recommends 63 minutes of pre-service time, 60 minutes of intra-service time, 30 minutes of immediate post service time, a half-day 99238 discharge day management and two 99213 Evaluation and Management office visits. The specialty societies noted, and the RUC agreed, that the survey median and 25th percentile work RVUs are inconsistent with the total physician work for 432X1 and are not relative to other similar procedures. Therefore, to determine an appropriate work value, the RUC recommends a direct crosswalk to CPT code 19301 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy* (work RVU = 10.13 and 60 minutes intra-service time). The RUC noted that both 432X1 and 19301 require the same intra-service time and almost identical total time. Additionally, both services require similar work intensity to perform and are both outpatient procedures. For additional support, the RUC referenced neighboring CPT codes 45171 *Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)* (work RVU = 8.13 and 45 minutes) and 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU = 11.90 and 75 minutes intra-service time). **The RUC recommends a work RVU of 10.13 for CPT code 432X1.**

432X2 ***Removal of esophageal sphincter augmentation device***
The specialty societies convened an expert panel and compared the survey median intra-service time for 432X2 (68 minutes) to the intra-service time for 432X1 (60 minutes) and 49320 *Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (intra-service time = 45 minutes) and agreed with the survey respondents that the removal of the esophageal sphincter augmentation device will require more time than the implantation. The RUC agreed and recommends 70 minutes of pre-service time, 68 minutes of intra-service time, 30 minutes of immediate post service time; a half-day 99238 discharge day management and two 99213 Evaluation and Management office visits. The specialty societies noted, and the RUC agreed, that the survey median and 25th percentile work RVUs are inconsistent with the total physician work for 432X2 and are not relative to other similar procedures. Therefore, to determine an appropriate work value, the RUC recommends a direct crosswalk to CPT code 47562 *Laparoscopy, surgical; cholecystectomy* (work RVU = 10.47 and 80 minutes intra-service time). The RUC noted that although 47562 requires more intra-service time than the aggregate survey median time for 432X2, the median intra-service time may be understated because of the number of people without experience. The RUC noted that the total time for these services is nearly identical and both require similar work and intensity. For additional support of a 10.47 work RVU for 432X2, the RUC referenced MPC codes 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77 and 60 minutes) and 57288 *Sling operation for*

stress incontinence (eg, fascia or synthetic) (work RVU = 12.13 and 60 minutes intra-service time). **The RUC recommends a work RVU of 10.47 for CPT code 432X2.**

Practice Expense
The Practice Expense Subcommittee corrected one typo on the number of visit packs. The RUC recommends the standard 090-day global direct practice expense inputs for CPT codes 432X1 and 432X2.

New Technology
The RUC recommends that codes 432X1 and 432X2 be placed on the new technology and re-survey once these services are more widely performed. It was noted that the American Society of General Surgeons (ASGS) thought that the RUC recommendation was insufficient to describe the physician work required for these services, even though cruroplasty is included in the descriptor.

Flag in RUC Database
The RUC recommends that this service be flagged in the RUC database as "Do not use to validate physician work" until this procedure is more widely performed and a RUC survey is conducted that results in the required minimum number of survey responses.

Laparoscopic Radiofrequency Ablation of Uterine Fibroids (Tab 18)
George Hill, MD (ACOG); Jon Hathaway, MD (ACOG)

In October 2015, the CPT Editorial Panel converted Category III code, 0336T, into Category I code 585X1 to report laparoscopic radiofrequency ablation of uterine fibroids.

The RUC reviewed the survey results from 40 physicians and determined that the survey 25th percentile work RVU of 14.08 appropriately accounts for the work required to perform CPT code 585X1. The RUC noted that this service requires 51 minutes pre-service time, 120 minutes intra-service time and 30 minutes immediate post-service time and a half-day 99238 discharge day. The specialty societies indicated, and the RUC agreed, that two 99213 office visits are appropriate as indicated by the survey respondents, which both include an expanded problem focused history and low complexity medical decision making.

The RUC compared the surveyed code to key reference codes *58546 Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g* (work RVU = 19.94 and intra-service time 180 minutes) and 58662 *Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method* (work RVU = 12.15 and 80 minutes intra-service time). For additional support, the RUC compared the surveyed code to MPC codes 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU = 14.56 and 120 minutes intra-service time) and *33249Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber* (work RVU = 15.17 and 120 minutes intra-service time) and determined that the survey 25th percentile work value for 585X1 appropriately ranks this new procedure with similar services and other MPC codes. **The RUC recommends a work RVU of 14.08 for CPT code 585X1.**

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

New Technology
The RUC recommends that CPT code 585X1 be placed on the New Technology list to examine after additional utilization data is available.

Endoscopic Decompression of Spinal Cord Nerve (Tab 19)
John Ratliff, MD (AANS); Alexander Mason, MD (CNS); Henry Woo, MD (CNS); Charles Mick, MD (NASS); Karin Swartz, MD (NASS); Morgan Lorio, MD (ISASS)

At the October 2015 CPT meeting, the CPT Editorial Panel established one new Category I code to report endoscopic decompression of neural elements.

The RUC reviewed the survey responses from 53 physicians and determined that a work RVU of 10.47 which was below the survey 25th percentile appropriately accounts for the work required to perform CPT code 630X1. The RUC recommends 231 minutes total time with 66 minutes pre-service time, 70 minutes intra-service time, 30 minutes of immediate post-service time, ½ day discharge, and 2-99213 office visits. The RUC compared the surveyed code to similar services 63030 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar* (work RVU=13.18 and 90 minutes intra-service time) and 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (work RVU=15.37 and 90 minutes intra-service time) and determined that these services required slightly higher intra-service time and physician work. Therefore, the specialty society recommended and the RUC agreed that 630X1 should be crosswalked to MPC code 47562 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (work RVU=10.47 and 80 minutes intra-service time) as these services require similar physician work and time to perform. **The RUC recommends a work RVU of 10.47 for CPT code 630X1.**

Practice Expense
The Practice Expense Subcommittee corrected equipment times. The RUC recommends the direct practice expense inputs as approved by the Practice Expense Subcommittee with a standard 90 day global package.

New Technology
CPT code 630X1 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.

Flag in RUC Database
The RUC recommends that this service be flagged in the RUC database as "Do not use to validate physician work".

Mammography-Computer Aided Detection Bundling (Tab 20)
Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR); Dana Smetherman, MD (ACR); Mark Alson, MD (SIR)

In October 2013, the mammography G-codes were identified via the CMS/Other Source – Utilization over 250,000 screen. In January 2014, the RUC noted that both CPT codes and G-codes exist to describe screening/diagnostic mammography. The RUC recommended that it analyze the screening/diagnostic mammography services G0202, G0204 and G0206 and CPT codes 77057, 77056 and 77055 in September 2014, after the Proposed Rule was released and CMS addressed the RUC recommendation to convert the direct practice expense medical supply inputs from film to digital. In the NPRM for 2015, CMS stated it would update the direct PE inputs for all imaging codes to reflect the migration from film to digital storage technologies since digital storage is now typically used in imaging. CMS confirmed that the majority of all mammography is currently digital. As a result, CMS proposed that the CPT codes 77055-77057 be used for reporting mammography to Medicare regardless of whether film or digital technology is used and to delete G0202, G0204 and G0206. CMS proposed for CY 2015, to value the CPT codes using the values established for the digital mammography G-codes. In addition, since the G codes proposed to use for CY 2015 have not been reviewed since they were created in CY 2002, CMS proposed to include 77055, 77056 and 77057 to the list of potentially misvalued codes. In September 2014, the RUC recommended that these services be surveyed for work and review direct practice expense inputs at the January 2015 meeting. Prior to survey, the RUC noted that this service be referred to CPT to remove "film" from the descriptor for 77057 and survey for work and review direct practice expense inputs for April 2015. In April 2015, the specialty society requested that these services be referred to the CPT Editorial Panel to bundle computer aided detection (CAD) which is typically performed along with mammography. The RUC recommended that these services be referred to the CPT Editorial Panel for revision for CPT 2017. In October 2015, the CPT Editorial Panel deleted codes 77051, 77052, 77055, 77056, 77057 and created three new codes to describe mammography services with bundled computer-aided detection (CAD) and assumes that CMS will delete G-codes G0202, G0204, and G0206.

Compelling Evidence
The specialty society noted and the RUC agreed that there is compelling evidence that diagnostic and screening mammography has changed due to new technology and a change in patient population. The previous survey conducted in 2000, was based on film screen technique which was typical at the time. Since that time, full-field digital mammography (FFDM) has become typical and the use of FFDM is reflected in the current survey and recommendations. It takes significantly more time and effort to interpret FFDMs than the older analog mammograms. Now, there is much greater detail available for analysis such as many more calcifications that require additional scrutiny which were not visible with analog mammograms. Additionally, the patient population has changed to more informed patients who are knowledgeable that they have heterogeneously dense or extremely dense breasts and have many more questions that require the radiologist's time and involvement. Currently 24 states have breast density notification laws, 8 states are considering similar legislation and there is a push for federal breast density notification legislation. Therefore, there is an increase in interpretation time and effort as there is greater demand for the radiologist to be a resource to the patients to answer questions regarding the technique, the radiation exposure, various screening protocols, supplemental and alternatives to mammography as well as provide the diagnostic exam results to all patients.

770X1 ***Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral***
The RUC noted that the current work RVU of this service is 0.76 (current mammography 0.70 + CAD 0.06). The RUC agreed that work has increased to provide this service and therefore the work RVU should be higher than currently. The RUC reviewed the survey results from 76 radiologists and determined that survey median work RVU of 0.84 was slightly too high relative to the small increase in physician time, 2 minutes, indicated by the survey respondents. The RUC noted that although the increase in time is small, it does account for a substantial percentage (10%) of the total service since it is 21 minutes total time. The RUC recommends a direct crosswalk to the key reference code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81). The RUC recommends 5 minutes of pre-service time, 10 minutes of intra-service time and 6 minutes of immediate post-service time. The RUC also compared the surveyed code to the second key reference service 76816 *Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus* (work RVU 0.85 and intra-service time of 15 minutes) and noted that the surveyed service requires slightly less physician time required to perform, therefore is valued appropriately. **The RUC recommends a work RVU of 0.81 for CPT code 770X1.**

770X2 ***Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral***
The RUC reviewed the survey results from 76 radiologists and determined that the survey median work RVU of 1.00 appropriately accounts for the physician work required to perform 770X2. The RUC indicated that 5 minutes of pre-time, 12 minutes of intra-service time and 7 minutes of immediate post-service time are appropriate for this bilateral service and noted that the times should probably be somewhat higher compared to the unilateral mammography time. The RUC compared the surveyed code to key reference services 76801 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU = 0.99 and 15 minutes intra-service time) and 74150 *Computed tomography, abdomen; without contrast material* (work RVU = 1.19 and 12 minutes intra-service time) and noted that the intensity and complexity, physician time and work RVU ranked appropriately in the middle of these two services. **The RUC recommends a work RVU of 1.00 for CPT code 770X2.**

770X3 ***Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed***
The RUC reviewed the survey results from 76 radiologists and determined that the current work RVU of 0.76 appropriately accounts for the physician work required to perform 770X3. The RUC noted that the survey responses displayed a narrow distribution, with the 25th percentile work RVU at 0.75 and the survey median work RVU at 0.80. The RUC recommended maintaining the current work RVU, the existing screening mammography plus CAD (0.70 + 0.06 = 0.76), which maintains appropriate relativity compared to the diagnostic bilateral examination. Screening mammograms are performed on asymptomatic women and require 4 minutes less time to complete compared to the diagnostic mammogram. The RUC compared the surveyed code to key reference services 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81 and 11 minutes intra-service time and 78227 *Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed* (work RVU = 0.90 and 15 minutes of intra-service time) and noted that 770X3 requires less

physician work, time and intensity to complete and is therefore valued lower. **The RUC recommends a work RVU of 0.76 for CPT code 770X3.**

Practice Expense
The Practice Expense Subcommittee decreased some atypical clinical labor staff time and supply items. The significant change was to add a new piece of equipment, *PACS mammography workstation*. Different then most equipment time, the equipment time for this professional workstation will be directly tied to physician work time. For the diagnostic mammography services (770X1 and 770X2) the pre-, intra- and post-service physician work time will be used to calculate the equipment minutes. For the screening mammography service (770X3) the pre- and intra-service physician work time will be used to calculate the equipment minutes. This is because it is typical for a woman undergoing diagnostic mammography to be escorted to the work station and shown images, but it is not typical for a woman undergoing diagnostic mammography to be escorted to the work station and shown images. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

G-Codes
The RUC assumes CMS will delete the associated G-codes for these services (G0202, G0204 and G0206).

Ophthalmoscopic Angiography (Tab 21)
Stephen Kamenetzky, MD (AAO); David Glasser, MD (AAO); John Thompson, MD (ASRS)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT codes 92235 *fluorescein angiography (includes multiframe imaging) with interpretation and report* and 92240 *indocyanine-green angiography (includes multiframe imaging) with interpretation and report* (work RVU = 1.10) were identified as part of this screen. The specialty determined that the two services are performed together for a measureable number of patients, typically with macular disease when 92240 is performed. The specialty submitted a code change proposal to the CPT Editorial Panel to create a new CPT code 922X4 *Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral* to be utilized when the services are performed together. The specialty also determined that 92235 and 92240 are both typically done bilaterally. The value of the services currently represents a unilateral service, so the CPT Editorial Panel revised the descriptors to reflect the typical patient and include language for the service to be performed unilaterally or bilaterally.

92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral*
The RUC reviewed the survey results from 75 ophthalmologists and retinal surgeons and recommends the following physician time components: pre-service time of 1 minute, intra-service time of 15 minutes and immediate post-service time of 1 minute. The RUC recognized that although the intra-service time remains consistent with the RUC survey conducted in 2012, the pre-service and post-service time has decreased. The RUC has incorporated these time decreases into the recommendations.

The RUC reviewed the survey respondents' work values and determined that the survey 25th percentile work value of 0.75, below the current work value appropriately captures the work and complexity of this service. The RUC compared the service to recently reviewed CPT code 93261, *Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system* (work RVU = 0.74, intra-service time of 15 minutes) and noted that the services have identical intra-service time and should be valued similarly. For additional support the RUC compared the surveyed code to key reference service CPT code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg;, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU = 0.50, intra-service time of 10 minutes) and noted that the surveyed code is requires more time and is more intense to perform, justifying the greater work value. **The RUC recommends a work RVU of 0.75 for CPT code 92235.**

92240 ***Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral***

The RUC reviewed the survey results from 57 ophthalmologists and retinal surgeons and recommends the following physician time components: pre-service time of 1 minute, intra-service time of 20 minutes and immediate post-service time of 1 minute. The specialty clarified that although this service is an indocyanine-green angiography alone the patient would have had a fluorescein angiography at a previous visit that was previously interpreted and part of the physician work of this service is to compare angiographic findings with previous studies and other diagnostic modalities. The RUC recognized significant time decreases as well as evolving physician work since the RUC survey in 1996 and incorporated these time decreases into the recommendations. When this service was last reviewed it was new technology that was only performed by 15-20% of retinal specialists. At that time indocyanine-green angiography was dangerous and could cause life-threatening adverse reactions. In addition, previously indocyanine-green angiography required more pre-service and post-service time than fluorescein angiography and today the two services require identical pre-service and post-service time.

The RUC reviewed the survey respondents' work values and determined that the survey 25th percentile work value of 0.80, below the current work value appropriately captures the work and complexity of this service. The RUC compared the service to key reference service CPT code 92002, Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient (work RVU = 0.88, intra-service time of 15 minutes, total time of 25) and noted that the service has less intra-service time, but greater total time and is more intense to perform, justifying the higher work value. For additional support the RUC compared the surveyed code to MPC list CPT code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81, intra-service time of 11 minutes, total time of 21 minutes) and noted that the surveyed code has slightly more total time, but is less intense to perform, justifying the slightly lower work value. **The RUC recommends a work RVU of 0.80 for CPT code 92240.**

922X4 ***Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral***

The RUC reviewed the survey results from 53 ophthalmologists and retinal surgeons and recommends the following physician time components: pre-service time of 1 minute, intra-service time of 20 minutes and immediate post-service time of 1 minute. The specialty clarified that this service is an indocyanine-green angiography and a fluorescein angiography performed during the same visit and both are interpreted as part of this service. When the physician conducts the two studies together there are the same amount of pictures as one study so the intra-service time is the same, however the physician work is higher because the physician is interpreting an additional study.

The RUC reviewed the survey respondents' work values and determined that the survey 25th percentile work value of 0.95 appropriately captures the work and complexity of this service. The RUC compared the service to key reference service CPT code 99202, *Office or other outpatient visit for the evaluation and management of a new patient,* (work RVU = 0.93, intra-service time of 15 minutes, total time of 22 minutes) and noted that the surveyed code has slightly more intra-service time, justifying the slightly higher work value. **The RUC recommends a work RVU of 0.95 for CPT code 922X4.**

Practice Expense
The PE Subcommittee discussed that these services are typically performed with an opthalmic evaluation and management code and verified that all overlapping clinical staff time was removed. Additionally, cleaning time was added in to clean the angiograophy room which is different then the opthalmic evaluation and management exam lane. The Subcommittee extensively reviewed the work of the clinical staff and determined that for the 922X4 code although the staff is performing two studies the photographs are done between each other accounting for only 2 additional minutes over the indocyanine-green angiography. The Subcommittee also replaced the opthalmic exam lane with an *exam table* (EF023) and *exam light* (EQ168). The RUC reviewed and approved the practice expense inputs as modified and approved by the PE Subcommittee.

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

Closure of Paravalvular Leak (Tab 22)
Richard Wright, MD (ACC); Cliff Kavinsky, MD, PhD (SCAI); Thad Waites, MD (ACC)

Facilitation Committee #1

935X1 ***Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve***
CPT code 935X1 is a new code to describe the work of closing a paravalvular leak in a previously placed mechanical mitral valve. The RUC reviewed the survey results from 52 cardiologists that perform transcatheter structural heart procedures and determined that the specialty society recommendation of 25.00 work RVUs, which was the survey 25th percentile and median, was not appropriate. The specialty revised their recommendation based on an increment of intensity to 20.04 work RVUs. The RUC noted that it was not the value of 20.04, but instead the methodology used to obtain the value that was not appropriate. The RUC was concerned that there is a lack of other 000 day global codes with a similar work RVU range and it would not be possible to find an appropriate crosswalk. The RUC determined an alternate approved methodology was needed to ensure an accurate valuation. The RUC noted

that CPT code 935X1 contains the work of 935X2 with the addition of a transseptal puncture (CPT code 93462 *Left heart catheterization by transseptal puncture through intact septum or by transapical puncture*, work RVU= 3.73). Therefore, the RUC added the incremental work of add-on code 93462 (work RVU= 3.73) to the RUC approved value of 17.97 for CPT code 935X2 to arrive a work RVU of 21.70 for 935X1. The RUC determined that a work RVU of 21.70, below the 25th percentile appropriately accounts for the work required to perform this service. The RUC compared the surveyed code to key reference services 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU = 24.39, intra-service time of 180) and 33477 *Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed* (work RVU = 25.00, intra-service time of 180) and noted that the intra-service time is greater justifying the greater work value.

The RUC recommends 40 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 15 minutes scrub/dress/wait time, 135 minutes intra-service time and 30 minutes immediate post-service time. The RUC noted that the typical patient receiving this service has had previous cardiac surgeries. This service is a low volume code that is exclusively performed in a hospital and the patient is sent home several days later. The specialty society explained that this service is similar to 935X2, but is a much more complex service technically, primarily because of the location of the mitral valve, and it requires more time and intensity to perform. The RUC noted that there is 15 minute intra-service difference between 935X1 and 935X2. If you multiply the 15 minutes of intra-service by the IWPUT of 935X2 (0.135), the resulting work RVU of 2.03 can then be added to the recommended value of 17.97 for 935X2 to arrive at a work RVU of 20.00. Given this additional support, the RUC was confirmed that a work RVU of 21.70 is appropriate. **The RUC recommends a work RVU of 21.70 for CPT code 935X1.**

935X2 ***Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve***

CPT code 935X2 is a new code to describe the work of closing a paravalvular leak in a previously placed mechanical aortic valve. The RUC reviewed the survey results from 50 cardiologists that perform transcatheter structural heart procedures and determined that a work RVU of 17.97, below the 25th percentile appropriately accounts for the work required to perform this service. This value is a direct crosswalk to CPT code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97). The RUC recommends 40 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 15 minutes scrub/dress/wait time, 120 minutes intra-service time and 30 minutes immediate post-service time. The RUC noted that the typical patients has had a least two cardiac surgeries, are considered at risk for another cardiac surgery and are very ill patients. This service is a low volume code that is exclusively performed in a hospital and the patient is sent home several days later. The RUC compared the surveyed code to key reference services 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU = 24.39, intra-service time of 180) and noted that the intra-service time is greater justifying the greater work value. **The RUC recommends a work RVU of 17.97 for CPT code 935X2 a direct crosswalk to CPT code 93580.**

935X3 ***Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (list separately in addition to code for primary service)***

CPT code 935X3 is a new add-on code to describe the additional work of closing a paravalvular leak in a previously placed mechanical aortic valve. The RUC reviewed the

survey results from 51 cardiologists that perform transcatheter structural heart procedures and determined that a work RVU of 8.00, the survey 25th percentile appropriately accounts for the work required to perform this service.

The RUC recommends 60 minutes intra-service time. The RUC noted that the survey data was strong and that the survey 25th percentile appropriately captures the time and intensity of this service. For additional support the RUC compared 935X3 to 33884 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure)* (work RVU = 8.20, 60 minutes total time). **The RUC recommends a work RVU of 8.00 for CPT code 935X3.**

Practice Expense
CPT codes 935X1 and 935X2 are both 000 day global, facility only services. The specialty recommended that they be allocated 30 minutes of pre-service time for extensive use of clinical staff time. The PE Subcommittee discussed the complexity of the patient and the amount of work that the clinical staff in the office have to do prior to these procedures and agreed with the time. The RUC reviewed and recommends the practice expense inputs as submitted by the specialty and approved by the PE Subcommittee.

New Technology
CPT codes 935X1, 935X2 and 935X3 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and specifically review utilization trends.

Application of On-body Injector with Subcutaneous Injection (Tab 23)
Robert Weinstein, MD (ASH)

At the October 2015 panel meeting the CPT Editorial Panel created a new code, CPT code 963XX *application of on-body injector (includes cannula insertion) for timed subcutaneous injection*, for the administration of neupogen following chemotherapy. The manufacturer of the on-body injector that administers the medication submitted the code proposal and presented to the Panel. Although the specialty society did not develop the code proposal they are strongly supportive of the application. The drug cannot be administered until 24 hours after chemotherapy and often patients are required to return to the office for administration. This is a considerable burden for those who live in rural areas and may have to travel hundreds of miles for such treatment and the specialty supports the service as it is an important method of administration for this drug.

As the specialty society prepared to survey CPT code 963XX, it was determined that a targeted sample was necessary to appropriately survey this code. This type of survey needs to be approved by the Research Subcommittee; however the deadline for approval had already passed. In a letter to the RUC the specialty requested that the survey be delayed to the April 2016 RUC meeting. Subsequent to that letter being submitted the specialty determined that there are other infusion codes 96372, 96374, 96375 are part of the same family as the new codes and that the codes should be surveyed together. The specialty also learned that other services in the family, 96372, 96374, 96375, are high volume and have been identified by the Relativity Assessment Workgroup for surveyed and review by the RUC at the October 2016 RUC meeting. It will be necessary to gain involvement from other specialty societies that perform infusion services. The societies that perform these services will review potential

changes to the overall family of infusion codes and provide revised introductory material for the CPT book. The specialties plan to survey the entire family of infusion services for the October 2016 RUC meeting.

The RUC considered the recommendation of the specialty and agreed that the new service along with three other codes in the family, CPT codes 96372, 96374 and 96375 should be surveyed for the October 2016 RUC meeting. The RUC also agreed with the recommendation that the new service 963XX should be carrier priced for 2017. **The RUC recommends survey of CPT codes 96372, 96374, 96375 and 963XX for review at the October 2016 RUC meeting and recommends to carrier price CPT code 963XX for 2017.**

Parent, Caregiver-focused Health Risk Assessment - PE Only (Tab 24)
Steven E. Krug, MD, FAAP (AAP); Jennifer R. Aloff, MD (AAFP)

The CPT Editorial Panel added two new codes 961X0 *administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument* and 961X1 *administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument* to be added to the Medicine section of CPT. Based on the permanence principle, which states that proposed revisions that constitute a meaningful change to a CPT code should be deleted and renumbered, 99420 will not be resequenced, instead it will be deleted from the Evaluation and Management (E/M) section.

The specialty societies originally requested 15 minutes of intra-service clinical staff time for the *Medical/Technical Assistant* (L026A). This request was based on the RUC recommendation of 15 minutes of intra-service clinical staff time for CPT code 96127 *Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument* at the April 2014 RUC meeting. The intra-service time for 96127 was subsequently refined by CMS to 7 minutes for the *Medical/Technical Assistant* (L026A). Although the PE Subcommittee purported that 96127 is very different than the new codes that are being reviewed, the specialties countered that this is not the case. In fact, the specialties noted that the assessments included in 96127, 961X0 and 961X1 are typically provided to an at-risk patient/caregiver more than once. More importantly, the specialties explained how subsequent administrations continue to require that the clinical staff explain the response choices in addition to scoring and documenting the instrument, since the questions included on the instruments rarely, if ever, become rote to at-risk patients/caregivers.

The PE Subcommittee countered that the new codes are replacing 99420 *Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal),* which will be deleted for 2017. 99420 has 15 minutes of time in the service period, but much of this time is duplicative of an E/M service, and the code only has 5 minutes of intra-service clinical staff time in the service period. Therefore, for 961X0 and 961X1, the PE Subcommittee believes that the fact that the clinical staff typically performs one of the two assessments each time an at-risk patient or caregiver returns to the office over the course of the patient's illness means that the clinical staff would only need to explain the purpose of the instrument and the response choices to the patient and/or family member the first time that the assessment is administered in addition to scoring and documenting the instrument. The PE Subcommittee assumed that on subsequent visits the patient or caregiver would already know the purpose of the assessment and would fill the assessment out independently. Based on its assumptions, the Subcommittee determined that if the assessment is typically repeated at each visit and requires

little explanation after the first administration, the PE inputs should represent the typical clinical staff work, which would be the scoring and documentation portion of the assessment only. The Subcommittee also discussed that this service will typically be reported with an E/M service. For these reasons the PE Subcommittee concluded that the recommended time of 15 minutes for the *Medical/Technical Assistant (L026A)* is not appropriate for these services and the appropriate time should be slightly lower than the clinical staff intra-service time for the reference code 96127. The PE Subcommittee reviewed the recommended direct PE inputs for these services and reduced the clinical staff time to 5 minutes.

The Subcommittee also discussed the *Beck Depression Inventory, Second Edition (BDI-II)*, a new supply that the specialty societies recommended, and determined that the supply is appropriate for 961X1,as this is the caregiver focused health risk assessment and calls for a depression inventory in the CPT descriptor. The Subcommittee determined that this supply input is not appropriate for 961X0, as this is the patient focused health risk assessment and calls for a health hazard appraisal in the CPT descriptor. The PE subcommittee recommends 4 sheets of *paper, laser printing (each sheet) (SK057)* for 961X0 to print and administer the appropriate assessment tool for the patient focused code.

When presenting to the RUC, the specialty societies recommended that this family of codes be surveyed for practice expense. The specialty societies used an expert panel to determine the staff time and medical supplies, the same process that is used for most PE recommendations. PE surveys have been utilized on occasion, and it would be possible for a PE survey to be created for this service. The specialty societies noted their concern that 5 minutes of clinical staff time undervalues the service and would like the data of a PE survey in order to either verify the PE Subcommittee's reduction or indicate that more time is appropriate. The RUC agreed that this is an important service and it is critical to get the PE inputs correct. **The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the PE Subcommittee. The recommended inputs will be submitted to CMS as interim for the CPT 2017 cycle. The specialty will administer a survey and present practice expense recommendations based on the survey at the April 2016 RUC meeting for the CPT 2018 cycle.**

IX. CMS Request/Relativity Assessment Identified Codes:

<u>Anesthesia for Intestinal Endoscopic Procedures (Tab 25)</u>
Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)

Facilitation Committee #1

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

The specialty society provided an overview of the anesthesia codes and how the base units were developed as well explained each quintile comparable to work RVUs as explained in the April 2007 Anesthesia Workgroup report.

Three important points that the RUC emphasized regarding anesthesia services are:

1) Anesthesia codes are not like the other codes in the RBRVS; the RUC cannot crosswalk from one anesthesia code to another because each anesthesia code may represent the anesthesia work for 40-100 different procedures.
2) The Post-Induction Period Procedure Anesthesia (PIPPA) intensity is the single differential measure for comparison of all anesthesia base codes. The correlation between the procedure and the anesthesia service is not strict.
3) Time is calculated outside of the base unit and cannot be used as a comparator in the same way that the RUC uses intra-service time.

The RUC agreed that a base unit is not the same as a work RVU but there is a formula to convert base units to work RVUs to provide the RUC with an idea where these services would fall within the RBRVS. The specialty society presented the comparison calculations as follows:

Biopsy of Skin Lesion (Tab 26)
Daniel M. Siegel (AADA)

In the Final Rule for 2016, CMS re-ran screen for the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT codes 11100 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion* (work RVU=0.81) and11101 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)* (work RVU=0.41) were identified by this screen to be reviewed at the January 2016 RUC meeting.

Prior to the January 2016 RUC meeting, the specialty society notified the RUC that their survey data displayed a bimodal distribution of responses with more outliers than usual. The specialty explained that the code descriptions do not distinguish between different types of biopsies and thus they would like to bring the biopsy of skin lesion codes back to the CPT Editorial Panel in May 2016 for refinement of the codes. In addition, the Specialty noted that certain diagnoses or services require larger and deeper biopsies, such as pigmented lesions, squamous cell carcinomas, biopsies for drug allergies, GVHD or obtaining DNA samples for genetic studies. The Specialty noted their anticipation that CPT will create a new code set, differentiating by the depth of the skin lesion necessary. **The RUC recommends referring CPT codes 11100 and 11101 to the CPT Editorial Panel for expected Panel review during the May 2016 CPT meeting and subsequent RUC review at the October 2016 RUC meeting.**

Injection of Tendon Sheath (Tab 27)
William Creevy MD (AAOS); John Heiner MD (AAOS); Anne Miller MD (ASSH); Tim Tillo DPM (APMA); Barry Smith MD (AAPMR)

In the Final Rule for 2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 20550 was identified by this screen. This service was presented for review of physician work and practice expense at the January 2016 RUC meeting.

The RUC reviewed the survey responses from 266 surgeons and physicians and determined that the survey median work RVU of 0.75 appropriately accounts for the work required to perform CPT code 20550. In addition, the survey time and work RVU confirm the results from the RUC's 2002 survey and recommendation. The RUC recommends 11 minutes pre-service time, 5 minutes intra-service time, and 5 minutes immediate post-service time. The RUC agreed that pre-time package 6A (*Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect*) is appropriate. The RUC also agreed with the specialty recommendation to subtract 12 minutes from the package time of 23 minutes to account for overlap in time with an Evaluation and Management (E/M) service that is reported more than 50% of time with 20550. The RUC noted that the recommended total pre-time of 11 minutes is consistent with the current pre-time of 10 minutes from the previous survey.

The RUC also agreed that the work value of 0.75 for 20550 fits well between the key reference services. Key reference code 20526, *Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel* (work RVU=0.94 and 5 minutes intra-service time) is more intense than 20550 because of the increased risk/intensity/complexity when injecting near the median nerve. When compared with key reference code 20600, *Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance* (work RVU=0.66 and 5 minutes intra-service time), the RUC agreed that injecting into the tendon sheath (20550) is technically more difficult than injecting or aspirating from a joint (20600). The RUC agreed that the work RVUs for codes 20600 and 29526 correctly bracket the work RVU for 20550. For additional support, the RUC referenced MPC code 67820 *Correction of trichiasis; epilation, by forceps only* (work RVU=0.71 and 5 minutes intra-service time) and agreed that injection of a tendon sheath was more complex/intense than removing aberrant eyelashes. Finally, the RUC considered 13 RUC reviewed injection/aspiration codes with 5 minutes of intra-service time and agreed that the work RVU of 0.75 appropriate places code 20550 relative to similar procedures, taking into consideration difference in work intensity. **The RUC recommends a work RVU of 0.75 for CPT code 20550.**

Practice Expense
The Practice Expense Subcommittee had an extensive discussion concerning the E/M visit that is billed on the same day. The Practice Expense Subcommittee reviewed and revised the clinical staff time inputs to ensure that any duplicative times with the E/M visit were removed. Additionally, he Practice Expense Subcommittee corrected the equipment minutes. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Injection of Trigger Points (Tab 28)
Barry Smith, MD (AAPMR)

In the Final Rule for 2016 CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT codes 20552-20553 were identified by this screen. These services were presented for review of physician work and practice expense at the January 2016 RUC meeting.

20552 ***Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)***
The RUC reviewed the survey responses from 64 physicians and determined that the survey 25th percentile work RVU of 0.66, which is also the current value, appropriately accounts for the work required to perform CPT code 20552. The RUC recommends 11 minutes pre-service time, 5 minutes intra-service time, and 5 minutes immediate post-service time. The RUC agreed that pre-time package 6A (Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect) is appropriate. The RUC also agreed with the specialties recommendation to subtract 12 minutes from the 23 minutes of pre-time in package 6A to account for overlap in time with an Evaluation and Management (E/M) service that is reported more than 50% of the times with 20552. Additionally, the RUC discussed the inclusion of 5 minutes of scrub, dress, and wait time. Although the procedure was previously designated as sterile, the previous survey was conducted prior to the creation of pre-service time packages, which standardized the physician work of procedures like this. Furthermore, the specialties indicated that practice has changed such that physicians have become more cognizant of the patient safety need to be cautious and ensure the fields remain completely sterile, which accounts for the appropriate inclusion of time for the sterile procedure.

The RUC noted that the work value of 0.66 for 20552 fits well between the key reference services. The RUC agreed that key reference codes 20600 *Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance* (work RVU=0.66 and 5 minutes intra-service time) and 20612 *Aspiration and/or injection of ganglion cyst(s) any location* (work RVU=0.70 and 5 minutes intra-service time), required the same intra-service time and comparable physician work. For additional support the RUC referenced MPC code 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU=0.84 and 10 minutes intra-service time). Finally, the RUC considered 11 RUC reviewed injection/aspiration codes with 5 minutes of intra-service time and agreed that the work RVU of 0.66 appropriately places code 20552 relative to similar procedures, taking into consideration difference in work intensity. **The RUC recommends a work RVU of 0.66 for CPT code 20552.**

20553 ***Injection(s); single or multiple trigger point(s), 3 or more muscle(s)***
The RUC reviewed the survey responses from 62 physicians and determined that the current work RVU of 0.75 appropriately accounts for the work required to perform CPT code 20553. The RUC recommends 12 minutes pre-service time, 10 minutes intra-service time, and 5 minutes immediate post-service time. The RUC agreed that pre-time package 6A (Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect) is appropriate. The RUC also agreed with the specialty recommendation to subtract 11 minutes from the package time of 23 minutes to account for overlap in time with an E/M service that is reported more than 50% of time with 20553. Additionally, the RUC discussed the inclusion of 5 minutes of scrub, dress, and wait time. Although the procedure was previously designated as

sterile, the previous survey was conducted prior to the creation of pre-service time packages, which standardized the physician work of procedures like this. Furthermore, the specialties indicated that practice has changed such that physicians have become more cognizant of the patient safety need to be cautious and ensure the fields remain completely sterile, which accounts for the appropriate inclusion of time for the sterile procedure.

The RUC compared the surveyed code to similar services 20605 *Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance* (work RVU=0.68) and 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel* (work RVU=0.94) and the RUC determined that these services required comparable physician work. For additional support the RUC referenced MPC code 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU=0.84 and 10 minutes intra-service time). Finally, the RUC considered 11 RUC reviewed injection/aspiration codes with 10 minutes of intra-service time and agreed that the work RVU of 0.75 appropriately places code 20553 relative to similar procedures, taking into consideration difference in work intensity. **The RVU recommends a work RUC of 0.75 for CPT code 20553.**

Practice Expense
The Practice Expense Subcommittee had an extensive discussion concerning the E/M visit that is billed on the same day. The Practice Expense Subcommittee reviewed and revised the clinical staff time inputs to ensure that any duplicative times with the E/M visit were removed. Additionally, the supply list was reviewed and revised to reflect actual supplies utilized instead of using the basic injection pack. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Endotracheal Intubation (Tab 29)
Ethan Booker, MD (ACEP); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)

In the Final Rule for 2016 CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 31500 *Intubation, endotracheal, emergency procedure* (work RVU=2.33) was identified by this screen. This service was presented for review of physician work and practice expense at the January 2016 RUC meeting.

Compelling Evidence
The specialty societies presented compelling evidence to suggest that the current work RVU is undervalued, as there were incorrect assumptions made in the previous valuation of the service based on a misleading vignette. Specifically, the previous vignette was not based on the typical patient being emergent, even though emergency physicians are the dominant provider of this service. The appropriate vignette has allowed for an accurate survey assessment and a more proper valuation reflecting proper time and intensity. The RUC agreed with the compelling evidence for this procedure.

The RUC reviewed the survey responses from 150 emergency physicians and anesthesiologists and determined that the survey 25th percentile work RVU of 3.00 appropriately accounts for the work required to perform CPT code 31500. The RUC recommends 12 minutes pre-service time, 10 minutes intra-service time, and 10 minutes

immediate post-service time. The RUC noted that given the unique, emergent nature of this procedure, there are few direct work RVU and physician time-based comparisons within the RBRVS. However, this does not mean the work RVU of 3.00 is not appropriate. First, this service is one of the most immediate, intense services physicians can perform. Second, the survey median intra-service time is 10 minutes, representing a doubling of the current time. Thus, 3.00 work RVUs is a reasonable increase over the current work RVU of 2.33, given both the prior survey deficiencies and the increase in time. It is also important to note that even with the increase in time, this service appropriately remains one of the foremost intense procedure in the RBRVS (RUC recommended IWPUT = 0.252). The RUC compared the surveyed code to similar services 92950 *Cardiopulmonary resuscitation (eg, in cardiac arrest)* (work RVU=4.00) and noted that while the physician time for 92950 is quite a bit longer than for the surveyed code, the physician work is comparable. However, the work of code 31500 is quite a bit more intense as the time is immediately intense, without ramp up or down time, which is the case with 92950. Therefore, the recommended value of 3.00 appropriately places the surveyed code below this reference code. 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU=2.82) For additional support the RUC referenced code 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU=2.82), MPC code 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands* (work RVU=2.82) and 62267 *Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes* (work RVU=3.00). The RUC again agreed that while the times for these reference codes are not identical to the surveyed code, the physician work is similar and, due to the unique, intense nature of code 31500, the recommended value is appropriate. **The RUC recommends a work RVU of 3.00 for CPT code 31500.**

CPT Assistant
The RUC also discussed the unique patient population treated with CPT code 31500. The specialty described that typically the same physician will report this on the same day as a critical care code (>50% of the time) but that this will not impact critical care code reporting. The specialty explained that underlying medical issues which caused the need for a patient to receive the intubation of CPT code 31500 and communication with family around the care of these issues is categorized within critical care time but time spent on this intubation would not count toward the critical care time. Given that you need at least 30 minutes for proper coding of critical care for patients, the RUC recommends that the specialty societies develop a CPT Assistant article to clarify when to report this service. The article will help ensure providers understand the times for these two services do not overlap.

Practice Expense
There are no direct practice expense inputs for this service because it is an emergent service that is only performed in the facility setting and does not have any clinical staff pre-service time because the dominant specialty is emergency medicine.

Insertion of Arterial Catheter (Tab 30)
Marc Leib, MD (ASA)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion*

(separate procedure); percutaneous (work RVU=1.15) was identified by this screen and was to be presented at the January 2016 RUC meeting.

Prior to the January 2016 RUC meeting, the specialty societies notified the RUC that CPT code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU=2.50) was to be reviewed by the RUC at the October 2016 meeting. The specialty requested that codes 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (work RVU=2.91) and 36620 be postponed to the October 2016 meeting so that they could survey all three codes together. **The RUC recommends deferring CPT codes 36556, 93503, and 36620 to the October 2016 RUC meeting.**

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU=1.15) was identified by this screen and was to be presented at the January 2016 RUC meeting.

Prior to the January 2016 RUC meeting, the specialty societies notified the RUC that CPT code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU=2.50) was to be reviewed by the RUC at the October 2016 meeting. The specialty requested that codes 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (work RVU=2.91) and 36620 be postponed to the October 2016 meeting so that they could survey all three codes together. **The RUC recommends deferring CPT codes 36556, 93503, and 36620 to the October 2016 RUC meeting.**

Bone Marrow Aspiration and Biopsy (Tab 31)
David H Regan, MD (ASCO)

In the NPRM for 2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 38221 was one of the services identified in this screen.

Prior to the January 2016 RUC meeting, the specialty societies notified the RUC of their plan to submit a code change application to the CPT Editorial Panel to revise these services. The societies indicated their plan to improve nomenclature for these codes (ie diagnostic vs therapeutic use) and to create a CPT code to replace G code G0364. **The RUC recommends referring CPT codes 38221, 38220 and G0364 to the CPT Editorial Panel**

Bladder Catheter (Tab 32)
Thomas Turk, MD (AUA); James Dupree, MD (AUA); Phil Wise, MD (AUA); Daniel Rukstalis, MD (AUA)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia

and Evaluation and Management services and services reviewed since CY 2010. CPT codes 51700 and 51702 were identified via this screen and CPT codes 51701 and 51703 were added as part of this family of services.

51700 ***Bladder irrigation, simple, lavage and/or instillation***
The RUC reviewed the survey responses from 99 urologists and determined that the survey 25th percentile work RVU of 0.60 appropriately accounts for the work required to perform this service. The RUC recommends the surveyed physician time of 15 minutes pre-service time, 5 minutes intra-service time and 5 minutes immediate post-service time. The RUC compared the surveyed code to key reference service 51705 *Change of cystostomy tube; simple* (work RVU = 0.90 and 10 minutes intra-service time) and noted that 51700 requires half the amount of intra-service time and the survey respondents indicated less intense on all of the psychological stress intensity measures, thus is appropriately valued lower. The RUC compared CPT code 51700 to 000-day global MPC code 67028 *Correction of trichiasis; epilation, by forceps only* (work RVU = 0.71 and 5 minutes intra-service time) and determined that the intra-service work is the same, thus valued similarly. For additional support, the RUC referenced similar 000-day global service 20550 *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU = 0.75 and 5 minutes of intra-service time). **The RUC recommends a work RVU of 0.60 for CPT code 51700.**

51701 ***Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)***
The RUC noted that CPT codes 51701, 51702 and 51703 were last valued as a direct crosswalk for physician work and time and the values and times were not based on a survey. These codes were flagged as not to be used to validate physician work. Therefore, the current work and time does not have any specific validity to use in comparison to the new survey data.

The RUC reviewed the survey responses from 108 urologists and determined that the survey 25th percentile work RVU of 0.50, and current work RVU, appropriately accounts for the work required to perform this service. The RUC recommends the surveyed physician time of 14 minutes pre-service time, 5 minutes intra-service time and 5 minutes immediate post-service time. The RUC noted that 51701 is typically reported with an Evaluation and Management service. The specialty society indicated and the RUC agreed that the pre-service time of 14 minutes does not overlap with an E/M service. The physician is choosing the catheter and deciding whether to give prophylactic antibiotics dependent on patient history whether there is an order for culture or cytology. The RUC compared the surveyed code to key reference service 51705 *Change of cystostomy tube; simple* (work RVU = 0.90 and 10 minutes intra-service time) noting that 51701 requires half the amount of intra-service time and the survey respondents indicated is overall less intense and complex on all of the psychological stress intensity measures, thus is appropriately valued lower. The RUC compared CPT code 51701 to MPC code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 5 minutes of intra-service time) and similar service 46600 *Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (work RVU = 0.55 and 5 minutes intra-service time), both of which support the survey 25th percentile work RVU of 0.50. **The RUC recommends a work RVU of 0.50 for CPT code 51701.**

51702 ***Insertion of temporary indwelling bladder catheter; simple (eg, Foley)***
The RUC noted that CPT codes 51701, 51702 and 51703 were last valued as a direct crosswalk for physician work and time and the values and times were not based on a survey.

These codes were flagged as not to be used to validate physician work. Therefore, the current work and time does not have any specific validity to use in comparison to the new survey data.

The RUC reviewed the survey responses from 115 urologists and determined that the current work RVU of 0.50 appropriately accounts for the work required to perform this service. The RUC determined that the physician work for the insertion of indwelling bladder catheter (CPT code 51702) and insertion of the non-dwelling catheter (CPT code 51701) is the same. The RUC recommends the surveyed physician time of 15 minutes pre-service time, 5 minutes intra-service time and 5 minutes immediate post-service time. The RUC compared the surveyed code to key reference service 51705 *Change of cystostomy tube; simple* (work RVU = 0.90 and 10 minutes intra-service time) noting that 51702 requires half the amount of intra-service time, thus is appropriately valued lower. The RUC compared CPT code 51702 to MPC code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 5 minutes of intra-service time) and similar service 46600 *Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (work RVU = 0.55 and 5 minutes intra-service time), both of which support a work RVU of 0.50. **The RUC recommends a work RVU of 0.50 for CPT code 51702.**

51703 ***Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)***
The RUC noted that CPT codes 51701, 51702 and 51703 were last valued as a direct crosswalk for physician work and time and the values and times were not based on a survey. These codes were flagged as not to be used to validate physician work. Therefore, the current work and time does not have any specific validity to use in comparison to the new survey data.

The RUC reviewed the survey responses from 112 urologists and determined that the current work RVU of 1.47 appropriately accounts for the work required to perform this service. The survey 25th percentile of 1.50 work RVUs supports maintaining the current work RVU. The RUC recommends the surveyed physician time of 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that the work required to perform this complicated insertion of catheter is appropriate relative to the simple insertion of a catheter. This service requires the physician to perform multiple attempts at catheter placement, often times there is a broken catheter that can not be removed, the patient is awake and uncomfortable with urine retention for some time. The RUC noted the pre-service evaluation time for this service is 5 minutes longer than for 51702 because the physician must take time to assess what was performed in the previous initial failed attempts to catheter. Additionally, 5 more minutes of immediate post-service time are required for this service versus 51702 in order to manage the patient's medication and determine how long the catheter should remain in place. The RUC compared the surveyed code to the second top key reference service 53855 *Insertion of a temporary prostatic urethral stent, including urethral measurement* (work RVU = 1.64 and 15 minutes intra-service time) noting that these services require the same intra-service time and similar intensity and complexity to perform. The RUC compared CPT code 51703 to MPC codes 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm* (work RVU = 1.44 and 17 minutes of intra-service time) and 57452 *Colposcopy of the cervix including upper/adjacent vagina;* (work RVU = 1.50 and 15 minutes intra-service time) and similar service 15271 *Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area* (work RVU = 1.50 and 15 minutes intra-service time) all of which support a work RVU of 1.47. **The RUC recommends a work RVU of 1.47 for CPT code 51703.**

Practice Expense
The Practice Expense Subcommittee eliminated any duplication in the pre-service time associated with other services reported with these services, added the standard catheter insertion kit, removed any supplies included in that kit and corrected the equipment minutes. The Subcommittee noted that the monitoring time following the procedure for these services is not a 1:4 ratio as with other monitoring time, rather it is a 1:1 ratio. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

Treatment of Bladder Lesion (Tab 33)
Thomas Turk, MD (AUA); James Dupree, MD (AUA); Phil Wise, MD (AUA); and Daniel Rukstalis, MD (AUA)

In the Final Rule for 2016 CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 51720 *Bladder instillation of anticarcinogenic agent (including retention time)* was identified via this screen.

The RUC reviewed the survey responses from 50 urologists and determined that the survey 25th percentile work RVU of 0.87 appropriately accounts for the work required to perform this service. The RUC recommends 9 minutes pre-service time, 5 minutes intra-service time and 5 minutes immediate post-service time. The RUC noted that the intra-service time significantly decreased since the last RUC review and agreed that for this specific service, a commensurate decrease in the recommended work is appropriate. The RUC compared the surveyed code to the key reference code 51705 *Change of cystostomy tube; simple* (work RVU = 0.90 and 10 minutes intra-service time) and noted that physician work is similar but 51720 requires less time and is slightly more intense and complex to perform than 51705. For additional support the RUC referenced MPC code 43760 *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance* (work RVU = 0.91 and 10 minutes intra-service time) and similar service 20550 *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU = 0.75 and 5 minutes intra-service time). **The RUC recommends a work RVU of 0.87 for CPT code 51720.**

Practice Expense
The Practice Expense Subcommittee eliminated some of clinical staff pre-service time because it is typically only performed on first of five sequential times done for this service. The PE Subcommittee added the clinical staff time to set up and mix Bacillus Calmette-Guerin (BCG), added the appropriate catheter insertion tray, removed associated duplicative supplies and corrected the equipment minutes. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

Electromyography Studies (EMG) (Tab 34)
Thomas Turk, MD (AUA); James Dupree, MD (AUA); Phil Wise, MD (AUA); Daniel Rukstalis, MD (AUA); Mitchell Schuster, MD (ACOG); George Hill, MD (ACOG)

Facilitation Committee #3

In the Final Rule for 2016 CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 51784 *Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique* was identified via this screen.

The RUC reviewed the survey results from 80 physicians and determined that the survey median work RVU of 0.75 appropriately accounts for the work required to perform CPT code 51784. The RUC recommends 15 minutes pre-service time, 20 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that while the survey times are nearly identical to the current times, the median survey work RVU is less than half of the current work RVU (1.53). The specialty confirmed and the RUC agreed that with 80 survey respondents, the survey is valid and an appropriate sample of the physicians who perform this service. The RUC noted that while this value results in a low IWPUT, the intensity of this procedure is low and compares well to other codes with similar physician time and work: 11310 *Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less* (work RVU= 0.80 and 20 minutes intra-service time) and 43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)* (work RVU= 0.81 and 20 minutes intra-service time). **The RUC recommends a work RVU of 0.75 for CPT code 51784.**

Practice Expense
The Practice Expense Subcommittee recommended the following modification: eliminated duplicative clinical staff time because this service is typically performed with another service, added a couple minutes for consent, deleted some supplies and corrected the equipment minutes. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

Cystourethroscopy (Tab 35)
Thomas Turk, MD (AUA); James Dupree, MD (AUA); Phil Wise, MD (AUA); Daniel Rukstalis, MD (AUA); George Hill, MD (ACOG); and Mitchell Schuster, MD (ACOG)

In the Final Rule for 2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 52000 *Cystourethroscopy (separate procedure)* was identified via this screen.

The RUC reviewed the survey responses from 162 physicians and determined that the survey 25th percentile work RVU of 1.75 appropriately accounts for the work required to perform CPT 52000. The RUC recommends 20 minutes pre-service time, 10 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that the decrease in intra-service time by 5 minutes from when it was last surveyed directly correlates to the recommended reduction in the work RVU. The RUC compared the surveyed code to the top key reference service 52005 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;* (work RVU = 2.37 and 30 minutes intra-service time) and noted that the physician time, work and intensity and complexity required to perform 52005 is much greater, thus the recommended RVU is appropriate. The RUC compared the surveyed code to the second key reference service 57420 *Colposcopy of the entire vagina, with cervix if present;* (work RVU = 1.60 and 19 minutes intra-service time) and noted the physician time is slightly higher, but the survey respondents indicated that CPT code 52000 is slightly more intense and complex to perform for all measures (mental effort, technical skill and psychological stress) and thus is appropriately valued slightly higher than 57420. For additional support the RUC referenced MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and 15 minutes intra-service time) and similar service 53620 *Dilation of urethral stricture by passage of filiform and follower, male; initial* (work RVU = 1.62 and 10 minutes intra-service time). **The RUC recommends a work RVU of 1.75 for CPT code 52000.**

Practice Expense
The Practice Expense Subcommittee made substantial reductions in pre-service clinical staff time and eliminated duplicative staff time as this service is typically reported with another procedure or Evaluation and Management service. The clinical staff time for cleaning the room was maintained because typically a different room is used for cystourethroscopy. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

<u>Biopsy of Prostate (Tab 36)</u>
Thomas Turk, MD (AUA); James Dupree, MD (AUA); Phil Wise, MD (AUA); Daniel Rukstalis, MD (AUA)

In the Final Rule for 2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* was identified via this screen.

The RUC reviewed the survey responses from 51 urologists and determined that the survey 25th percentile work RVU of 2.50 appropriately accounts for the work required to perform CPT code 55700. The RUC recommends 15 minutes pre-service time, 15 minutes intra-service time and 5 minutes immediate post-service time. The RUC noted that the intra-service time of 15 minutes indicated by the survey respondents confirms the current intra-service time of 15 minutes. The RUC compared the surveyed code to similar services 93503 *Insertion and*

placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes (work RVU = 2.91 and 15 minutes intra-service time) and 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50 and 15 minutes intra-service time) and the RUC determined that these services required the same intra-service time and comparable physician work. For additional support the RUC referenced MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and 15 minutes intra-service time). The RUC recommends a work RVU of 2.50 for CPT code 55700.

Practice Expense
The Practice Expense Subcommittee reduced and modernized the clinical staff pre-service time and adjusted the post-service time for cleaning, added supply item *SA042 pack, cleaning and disinfecting, endoscope* and corrected the equipment minutes. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

Hysteroscopy (Tab 37)
George Hill, MD (ACOG); and Jon Hathaway, MD (ACOG)

In the NPRM for 2016 CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 58558 was identified by this screen and 58559-58563 were included as part of the family. These services were presented for review of physician work and practice expense at the January 2016 RUC meeting.

58555 *Hysteroscopy, diagnostic*
The RUC reviewed the survey results from 61 practicing gynecologists and agreed with the following time components: pre-service time of 56 minutes, intra-service time of 20 minutes and immediate post-service time of 20 minutes. The RUC agreed to add 5 minutes of positioning time to place the patient in the dorsal lithotomy position.

The RUC reviewed the survey respondents' physician work values and agreed that the appropriate value is between the median value (work RVU= 3.45) and 25th percentile (work RVU= 2.65). The RUC noted a 5 minute decrease in the survey intra-service time from the current time and therefore agreed that the current work RVU of 3.33 should be lower. The RUC compared the surveyed code to CPT code 43250 *Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps* (work RVU= 3.07, intra time= 20 minutes) and noted that both services have identical intra-service time and comparable physician work. Therefore, the RUC agreed to directly crosswalk the work RVUs from code 43250 to CPT code 58555. To justify a work RVU of 3.07, the RUC reviewed CPT code 41530 *Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session* (work RVU= 3.50, intra time= 20 minutes). Finally, the RUC noted that while the intra-service time has decreased the resulting work RVU should not be equivalently lowered. Since the last survey in 1997, the equipment has advanced so that more of the intra-service time is spent actually performing the surgery and not trying to clean the blood, mucus or air out of the uterus. Additionally, the equipment allows for higher flow volumes, which

must be monitored closely to ensure the patient doesn't get overloaded. **The RUC recommends a work RVU of 3.07 for CPT code 58555.**

58558 ***Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C***
The RUC reviewed the survey results from 66 practicing gynecologists and agreed with the following time components: pre-service time of 56 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. The RUC agreed to add 5 minutes of positioning time to place the patient in the dorsal lithotomy position.

The RUC reviewed the survey respondents' physician work values and agreed that the appropriate value is between the median value (work RVU= 4.63) and 25th percentile (work RVU= 3.14). To determine an appropriate value, the RUC compared the surveyed code to CPT code 43243 *Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices* (work RVU= 4.37, intra time= 30 minutes) and noted that both services have identical intra-service time and comparable physician work. Therefore, the RUC agreed to directly crosswalk the work RVUs from code 43243 to CPT code 58558. To justify a work RVU of 4.37, the RUC reviewed CPT codes 45385 *Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* (work RVU= 4.67, intra time= 30 minutes) and 52234 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)* (work RVU= 4.62, intra time= 30 minutes) and agreed that both services provide strong support for the recommended value. **The RUC recommends a work RVU of 4.37 for CPT code 58558.**

58559 ***Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)***
The RUC reviewed the survey results from 32 practicing gynecologists and agreed with the following time components: pre-service time of 56 minutes, intra-service time of 40 minutes and immediate post-service time of 20 minutes. The RUC agreed to add 5 minutes of positioning time to place the patient in the dorsal lithotomy position.

The RUC reviewed the survey respondents' physician work values and agreed that the appropriate value is between the median value (work RVU= 6.28) and 25th percentile (work RVU= 3.65). To determine an appropriate value, the RUC compared the surveyed code to CPT code 93455 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography* (work RVU= 5.54, intra time= 40 minutes) and noted that both services have identical intra-service time and comparable physician work. Therefore, the RUC agreed to directly crosswalk the work RVUs from code 93455 to CPT code 58559. To justify a work RVU of 5.54, the RUC reviewed CPT code 36222 *Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed* (work RVU= 5.53, intra time= 40 minutes) and 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, intra time= 45 minutes) and agreed that both services provide strong support for the recommended value. **The RUC recommends a work RVU of 5.54 for CPT code 58559.**

58560 ***Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)***
The RUC reviewed the survey results from 31 practicing gynecologists and agreed with the following time components: pre-service time of 56 minutes, intra-service time of 40 minutes and immediate post-service time of 20 minutes. The RUC agreed to add 5 minutes of positioning time to place the patient in the dorsal lithotomy position.

The RUC reviewed the survey respondents' physician work values and agreed that the appropriate value is between the median value (work RVU= 6.90) and 25th percentile (work RVU= 4.05). To determine an appropriate value, the RUC compared the surveyed code to CPT code 93456 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization* (work RVU= 6.15, intra time= 40 minutes) and noted that both services have identical intra-service time and comparable physician work. Therefore, the RUC agreed to directly crosswalk the work RVUs from code 93456 to CPT code 58560. To justify a work RVU of 6.15, the RUC reviewed the top key reference code 52282 *Cystourethroscopy, with insertion of permanent urethral stent* (work RVU= 6.39, intra time= 50 minutes) and CPT code 36222 *Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed* (work RVU= 5.53, intra time= 40 minutes) and agreed that both services provide strong support for the recommended value. Finally, the RUC noted that while this service has identical times to 58559, code 58560 is a more intense procedure and the recommended value maintains the appropriate relativity as established since this code family has existed. **The RUC recommends a work RVU of 6.15 for CPT code 58560.**

58561 ***Hysteroscopy, surgical; with removal of leiomyomata***
The RUC reviewed the survey results from 48 practicing gynecologists and agreed with the following time components: pre-service time of 56 minutes, intra-service time of 45 minutes and immediate post-service time of 20 minutes. The RUC agreed to add 5 minutes of positioning time to place the patient in the dorsal lithotomy position.

The RUC reviewed the survey respondents' physician work values and agreed that the median work RVU of 7.00 accurately values the physician work involved in CPT code 58561. To justify a work RVU of 7.00, the RUC compared the surveyed code to CPT codes 52344 *Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 7.05, intra time= 45 minutes) and MPC code 52352 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included) (work RVU= 6.75, intra time= 45 minutes) and agreed that both services provide strong support for the recommended value. **The RUC recommends a work RVU of 7.00 for CPT code 58561.**

58562 ***Hysteroscopy, surgical; with removal of impacted foreign body***
The RUC reviewed the survey results from 57 practicing gynecologists and agreed with the following time components: pre-service time of 56 minutes, intra-service time of 25 minutes and immediate post-service time of 20 minutes. The RUC agreed to add 5 minutes of positioning time to place the patient in the dorsal lithotomy position.

The RUC reviewed the survey respondents' physician work values and agreed that the appropriate value is between the median value (work RVU= 4.50) and 25th percentile (work

RVU= 3.20). To determine an appropriate value, the RUC compared the surveyed code to CPT code 45384 *Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps* (work RVU= 4.17, intra time= 28 minutes) and noted that while the reference code has slightly more intra-service time, code 58562 has more total time, 101 minutes compared to 70 minutes. Therefore, the RUC agreed to directly crosswalk the work RVUs from code 45384 to CPT code 58562. To justify a work RVU of 4.17, the RUC reviewed CPT code 15277 *Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children* (work RVU= 4.00, intra time= 25 minutes) and the second key reference code 57461 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix* (work RVU= 3.43, intra time= 28 minutes) and agreed that both services provide strong support for the recommended value. **The RUC recommends a work RVU of 4.17 for CPT code 58562.**

58563 ***Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)***
The RUC reviewed the survey results from 44 practicing gynecologists and agreed with the following time components: pre-service time of 56 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. The RUC agreed to add 5 minutes of positioning time to place the patient in the dorsal lithotomy position.

The RUC reviewed the survey respondents' physician work values and agreed that the appropriate value is between the median value (work RVU= 4.50) and 25th percentile (work RVU= 3.20). To determine an appropriate value, the RUC compared the surveyed code to CPT code 52234 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)* (work RVU= 4.62, intra time= 30 minutes) and noted that both services have identical intra-service time and comparable physician work. Therefore, the RUC agreed to directly crosswalk the work RVUs from code 52234 to CPT code 58563. To justify a work RVU of 4.62, the RUC reviewed MPC code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU= 4.71, intra time= 30 minutes) and CPT code 52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy* (work RVU= 4.05, intra time= 30 minutes) and agreed that both services provide strong support for the recommended value. Finally, the RUC noted that while this procedure has identical time components to the family code 58558, CPT code 58563 is a more intense procedure due to the increased risk of injury to other pelvic organs, notably bladder and bowel. The risk of injury to bladder is increased, since the previous valuation, due to the higher rate of cesarean delivery with a subsequent increase in non-union or thinness of the hysterotomy scar. **The RUC recommends a work RVU of 4.62 for CPT code 58563.**

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

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

Intracranial Endovascular Intervention (Tab 38)
Alexander Mason, MD (CNS); John Ratliff, MD (AANS); Henry Woo, MD (CNS); Michael Hall, MD (SIR); Joshua A. Hirsch, MD (ASNR); Gregory N. Nicola, MD (ASNR); Zeke Silva, MD (ACR)

In February 2015, the CPT Editorial Panel created three new codes to describe percutaneous endovascular revascularization of occluded cerebral vessels and intracranial prolonged infusion of agents that do not involve thrombolytic agents. CPT codes 61640-61642 were identified as part of that family of services. The specialty societies indicated the balloon dilatation of intracranial vasospasm codes are not part of the family of services. These services are of the same anatomic distribution but a completely different intervention and are not commonly used. Additionally, these codes assume that a separate diagnostic angiography is reported prior to the intervention. The specialty societies indicated that this would be very confusing for surveyees to value the variable coding techniques for both sets of services. The RUC determined that although CPT codes 61640-61642 may present difficulties in conducting a survey, it has been nearly 10 years since their last RUC review and they should be surveyed. The RUC recommended that CPT codes 61640-61642 be surveyed for October 2015.

At the October 2015 RUC meeting the specialty societies indicated they had used the wrong survey instrument. The specialty societies believe that the patients receiving these services will return to the ICU after the procedure and additional Evaluation and Management (E/M) work at the bedside and in the ICU later the same day will be necessary. The specialty society agreed to survey with the Research Committee approved 000-day global survey instrument modified with the site of service and same day E/M questions to determine the typical work on the day of the procedure. CPT codes 61645, 61650 and 61651 were surveyed with a modified 000-day global period survey and a post-operative visit was included in the RUC recommended values. The specialty requested that CPT 61640 be resurveyed with the modified survey instrument for January 2016. Since CPT code 61640 is the base code for 61641 and 61642, the RUC requested that the specialty societies resurvey all three codes for the January 2016 RUC meeting.

61640 ***Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel***
The RUC agreed that there was compelling evidence that the current value may not be appropriate due to flawed methodology in the previous valuation of these services. Originally this service was surveyed as a 090-day global and then a building block methodology was used to recommend the current work RVU.

The RUC reviewed the survey results from 73 physicians and determined that the survey 25th percentile work RVU of 13.00 appropriately accounts for the work required to perform this service. The RUC recommends 58 minutes pre-service time, 90 minutes intra-service time, 30 minutes immediate post-service time and one99233. During the intra-service period, typically there is a single waiting period, but if there is rebound stenosis period the physician would have to further intervene. The RUC understood that the patient is assessed over 4-6 hours and can deteriorate quickly in a short amount of time and must be assessed frequently. The specialty society noted that the physician performing the procedure will conduct a 99233 hospital visit to assess the efficacy of the procedure neurologically, review radiographic images to determine if stroke has been extended or hemorrhage occurred, and manage ICP issues of this hyper-dynamic critically ill patient. Because vasospasm is progressive, the physician must continually assess if patient requires further intervention. The RUC reviewed the survey data and noted that the diagnostic angiography is reported separately and that work is not included in this service. The RUC compared the surveyed code to the top two key

reference services 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU = 15.00 and 135 minutes intra-service time) and 92941 *Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel* (work RVU = 12.56 and 70 minutes intra-service time) and noted that the surveyed service falls in between these two services regarding the physician work and time required. Therefore, the survey 25th percentile work RVU of 13.00 is appropriate relative to similar services. **The RUC recommends a work RVU of 13.00 for CPT code 61640.**

61641 ***Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular family (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 73 physicians and determined that the median and survey 25th percentile work RVUs are too high, noting the top two key reference services chosen required more physician work and time and were not comparable. The RUC recommends maintaining the work RVU of 4.33 for CPT code 61641. The RUC recommends 30 minutes intra-service time, as was indicated by the survey respondents. For additional support, the RUC referenced CPT code 36228 *Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)* (work RVU = 4.25 and 30 minutes intra-service time) and the RUC noted that CPT code 61641 actually includes the work of 36228 plus somewhat more. **The RUC recommends a work RVU of 4.33 for CPT Code 61641.**

61642 ***Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 69 physicians and determined that the median and survey 25th percentile work RVUs are too high, noting the top two key reference services chosen required more physician work and time and were not comparable. The RUC recommends directly crosswalking 61642 to CPT code 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)* (work RVU = 6.50 and 45 minutes intra-service time). The RUC recommends 45 minutes intra-service time for 61642, as was indicated by the survey respondents. For additional support the RUC referenced CPT code 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43 and 40 minutes intra-service time). **The RUC recommends a work RVU of 6.50 for CPT code 61642.**

Practice Expense
These services are performed in the facility only. The RUC does not recommend any direct practice expense inputs.

MRI Face and Neck (Tab 39)
Zeke Silva III, MD (ASNR); Kurt Schoppe, MD (ACR); Greg Nicola, MD (ASNR)

In the NPRM for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by

specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 70543 was identified by this screen and 70540 and 70542 were included as part of the family. These services were presented for review of physician work and practice expense at the January 2016 RUC meeting.

Prior to reviewing the survey results for these MRI face and neck codes, the RUC discussed the physician time components and evolving physician work for the entire family. First, the RUC noted that the current physician time components are flawed. CPT code 70540 has CMS/Other time of 28 minutes, which as the RUC has noted previously, is not surveyed time and is the result of a single CMS official assigning time in rulemaking over 20 years ago. Also, for codes 70542 and 70543, last surveyed in 2000, the intra-service time for these procedures is identical. In every other MRI family, there are services for "with contrast" and "with and without contrast" which have an incremental increase in intra-service time for the most complex work "with and without contrast." These current surveys correct that error.

Second, although the specialty societies did not present compelling evidence, the physician work involved in these procedures has changed substantially since the last the last valuation over 15 years ago. Modern pulse sequences allow thinner slice profiles, leading to an increase in the number of images typically acquired. The thinner slice profile has led to the detection of subtle abnormalities not visible with older techniques. This includes detection of perineural inflammation, perineural tumor spread, tumor cellularity and vascularity, as well as intracranial extension via skull base foramen.

Given these arguments, the RUC agreed that while the surveys show changes in the physician times for these procedures, the current work RVUs, which are appropriately aligned relative to the other MRI brain and spine families, should remain the same.

70540 ***Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)***
The RUC reviewed the survey results from 56 practicing radiologists and neuroradiologists and agreed with the following survey median times: pre-service evaluation time of 5 minutes, intra-service time of 19 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results overvalued the procedure with a 25th percentile work RVU of 1.55. Therefore, the RUC recommended the current work RVU of 1.35 for CPT code 70540. To justify a work RVU of 1.35, the RUC compared the surveyed code to the top two key reference codes 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (work RVU= 1.48, intra time= 18 minutes) and 72141 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material* (work RVU= 1.48, intra time= 20 minutes) and agreed that since the MRI of the face and neck is a less complex procedure compared to the equivalent brain and spine codes, the recommended value is appropriately less than these reference points. To further validate the recommended value, the RUC reviewed the other two spine MRI codes 72146 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material* (work RVU= 1.48) and 72148 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material* (work RVU= 1.48). **The RUC recommends a work RVU of 1.35 for CPT code 70540.**

70542 ***Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)***
The RUC reviewed the survey results from 56 practicing radiologists and neuroradiologists and agreed with the following survey median times: pre-service evaluation time of 5 minutes, intra-service time of 20 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results overvalued the procedure with a 25th percentile work RVU of 1.80. Therefore, the RUC recommended the current work RVU of 1.62 for CPT code 70542. To justify a work RVU of 1.62, the RUC compared the surveyed code to the top two key reference codes 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)* (work RVU= 1.78, intra time= 20 minutes) and 72142 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)* (work RVU= 1.78, intra time= 23 minutes) and agreed that since the MRI of the face and neck is a less complex procedure compared to the equivalent brain and spine codes, the recommended value is appropriately less than these reference points. To further validate the recommended value, the RUC reviewed the other two spine MRI codes 72147 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)* (work RVU= 1.78) and 72149 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)* (work RVU= 1.78). **The RUC recommends a work RVU of 1.62 for CPT code 70542.**

70543 ***Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences***
The RUC reviewed the survey results from 56 practicing radiologists and neuroradiologists and agreed with the following survey median times: pre-service evaluation time of 5 minutes, intra-service time of 25 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' physician work values and agreed that the survey results overvalued the procedure with a 25th percentile work RVU of 2.28. Therefore, the RUC recommended the current work RVU of 2.15 for CPT code 70543. To justify a work RVU of 2.15, the RUC compared the surveyed code to the top two key reference codes 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (work RVU= 2.29, intra time= 25 minutes) and 72156 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical* (work RVU= 2.29, intra time= 25 minutes) and agreed that since the MRI of the face and neck is a less complex procedure compared to the equivalent brain and spine codes, the recommended value is appropriately less than these reference points. To further validate the recommended value, the RUC reviewed the other two spine MRI codes 72157 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic* (work RVU= 2.29) and 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU= 2.29). **The RUC recommends a work RVU of 2.15 for CPT code 70543.**

Practice Expense:
The Practice Expense Subcommittee set a new precedent to include a professional work station in addition to the currently included PACS work station. The time allocated to this work station, for these codes, includes the pre and intra-service time, specifically for the physician to review and prepare the report.

Radiation Treatment Devices (Tab 40)
Michael Kuettel, MD, PhD (ASTRO); Peter Orio, III, DO, MS (ASTRO); Gerald White, MS (ASTRO); Jim Goodwin, MS (ASTRO)

In the Final Rule for 2016 CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

The services represent an increment of complexity from the simple to the intermediate to the complex. CPT codes 77333 (intermediate) and 77334 (complex) both include 5 minutes of post-service time. During the post-service time the physician reviews a treatment device checklist that encompasses components to review the accuracy of the indexed coordinates of the treatment device, the accuracy of the treatment device descriptions, proper written documentation of the treatment device construction, proper photographic depiction of the treatment device construction, as well as cross referencing the pictures to the written coordinates and instructions for reproducibility. CPT code 77332 for the simple treatment device includes 3 minutes of post-service time because the checklist is slightly less involved. The work involved with these services describes the physician work associated with the fabrication of the device specifically designed for an individual patient's treatment course. The use of an immobilization device is determined by the clinical judgment of the radiation oncologist based on the clinical circumstances, patient anatomy and disease state. The purpose of the device, the risks involved by its use or non-use, and the complexity of its design determine the complexity level.

77332 ***Treatment devices, design and construction; simple (simple block, simple bolus)***
The RUC reviewed the survey results from 122 radiation oncologists and recommends the following physician time components: pre-service time of 0 minutes, intra-service time of 15 minutes and immediate post-service time of 3 minutes.

For a prostate patient as described by the vignette, the patient is set up on a low attenuating index board. Both arms are positioned across the chest, and the head positioned in a headrest. The treatment device (i.e. knee/foot immobilizer system) is positioned on the rigid fixation device. The patient's legs are then placed into the device. The position, angle, and indexing of the knee/foot immobilizer system is adjusted to correct for the pelvic tilt, rotations, alignment and patient tolerance and musculoskeletal limitations. Once a satisfactory position is obtained, the treatment device is locked into position. The physician assesses stability, potential daily reproducibility and obstructions which could interfere with the delivery of radiation. The physician then directs the measurements from reproducible reference points on the patient's anatomy relative to the immobilization device as well as device location markers to assure the treatment device can be accurately reproduced with the patient in the same set up position within the device. Localization photographs are taken and approved by the physician. The radiation therapist is assisting the physician for 75% of the intra-service time.

The RUC reviewed the survey respondents' work values and agreed that the specialties recommendation to maintain the work value (work RVU= 0.54) below the survey 25th percentile is appropriate for this service. The RUC noted that it is not appropriate to compare the surveyed time to the current CMS/Other source time, which represents time, not derived from a survey, but assigned by CMS over 20 years ago. The RUC compared this service to key reference service CPT code 77280, *Therapeutic radiology simulation-aided field setting; simple*

(work RVU = 0.70, intra time of 25 minutes) and noted that the reference code has more intra-service and total time compared to the surveyed code, justifying the greater work value. For additional support the RUC compared 77332 to 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* (work RVU = 0.62, intra-service time of 15 minutes) and noted that the reference code has identical intra-service time and is more intense to perform, justifying the greater work value. **The RUC recommends a work RVU of 0.54 for CPT code 77332.**

77333 ***Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)***
The RUC reviewed the survey results from 120 radiation oncologists and recommends the following physician time components: pre-service time of 0 minutes, intra-service time of 20 minutes and immediate post-service time of 5 minutes.

For a breast patient post mastectomy as described by the vignette, the patient is set up based on clinical circumstances, patient anatomy, disease state and physical limitations of the patient. The physician chooses bolus of the appropriate material and thickness. The thickness of bolus applied is dependent on the skin dose required and the angle of incidence of the treatment beams. Different thicknesses of bolus are used to increase dose homogeneity and modify surface dose deposition patterns. Bolus is also used to correct surgical deficits and create tissue equivalents. The physician verifies that the bolus has been heated/cut appropriately and the thickness is as prescribed. The physician shapes the bolus on the patient's chest wall with respect to the medial/lateral/cranial and caudal borders. Additional thickness of bolus is applied by the physician as necessary to modify the surface dose or adjust for post-surgery contour changes. The physician assesses stability and the potential daily reproducibility. He/she marks the bolus and the skin to ensure reproducibility. The physician directs the measurements from reproducible reference points on the patient's anatomy relative to the immobilization device to assist with daily accurate placement and reproducibility of the patient setup in the device. Localization photographs are taken and approved by the physician. The radiation therapist is assisting the physician for 75% of the intra-service time.

The RUC reviewed the survey respondents' estimated work values and agreed that the specialties recommendation to maintain the work value (work RVU= 0.84) below the survey 25th percentile is appropriate for this service. The RUC noted that it is not appropriate to compare the surveyed time to the current time CMS/Other source time, which represents time, not derived from a survey, but assigned by CMS over 20 years ago. The RUC compared the service to key reference service CPT code 77285, *Therapeutic radiology simulation-aided field setting; intermediate* (work RVU = 1.05, intra time of 40 minutes) and noted that the reference code has more intra-service and total time compared to the surveyed code, justifying the greater work value. For additional support the RUC compared 77332 to 77331 *Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician* (work RVU = 0.87, intra-service time of 30 minutes) and noted that the reference code has more intra-service time, justifying the greater work value. **The RUC recommends a work RVU of 0.84 for CPT code 77333.**

77334 ***Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)***
The RUC reviewed the survey results from 131 radiation oncologists and recommends the following physician time components: pre-service time of 0 minutes, intra-service time of 30 minutes and immediate post-service time of 5 minutes.

When CPT code 77334 is used for an immobilization device, it can only be reported once per course of treatment. Other types of treatment devices, for example, beam aperture shaping, may be used and reported. However, no more than one beam aperture device per field or gantry angle may be reported. The RUC noted that this service is typically reported on the same day as a simulation CPT code 77290 *Therapeutic radiology simulation-aided field setting; complex*, which is a simulation code (reported once per course of treatment) and includes outlining all the field edges, determining the isocenter (of the treatment area), analyzing all the CT data sets, applying all the fields to the target areas and adjusting the isocenter, identifying/reviewing "the path of each field through the patient" and ensuring maximum normal tissue spare. The description of physician work for 77290 includes "The patient is positioned after selecting the appropriate breast board and arm position both ipsilateral and contralateral." That refers to the work of creating a treatment device, which is the step prior to the simulation day. The specialty noted and the RUC agreed that there is no duplication of tasks if these services are reported together. The RUC recommends no pre-service time to ensure that there is no duplication in work in pre time when/if these codes are reported together. The RUC recommends 5 minutes of physician post time for the physician to review and approve the device-indexing checklist and documentation to the patient's chart.

The RUC reviewed the survey respondents' work values and agreed that the specialty societies' recommendation to maintain the work value (work RVU= 1.24) below the survey 25th percentile is appropriate for this service. The RUC compared the service to key reference service CPT code 77290, *Therapeutic radiology simulation-aided field setting; complex* (work RVU = 1.56, intra time of 60 minutes) and noted that the reference code has more intra-service and total time compared to the surveyed code, justifying the greater work value. For additional support the RUC compared 77334 to 77306 *Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)* (work RVU = 1.40, intra-service time of 40 minutes) and noted that the reference code has more intra-service and total time compared to the surveyed code, justifying the greater work value. **The RUC recommends a work RVU of 1.24 for CPT code 77334.**

Practice Expense
The Practice Expense Subcommittee approved compelling evidence for the simple and intermediate codes to increase in clinical staff time, as well as new supplies and equipment. The RUC reviewed and approved the direct practice expense inputs as submitted by the specialty society and approved by the PE Subcommittee.

Special Radiation Treatment (Tab 41)
Michael Kuettel, MD, PhD (ASTRO); Peter Orio, MD (ASTRO); Gerald White, MS (ASTRO); James Goodwin, MS (ASTRO)

In the Final Rule for 2016 CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

This service is only reported in situations where significant additional work is required to treat the patient. Proper documentation demonstrating medical necessity is always required with 77470. This code can only be reported once for the entire course of therapy and would not be reported alone. To ensure there is no duplication of work with other services this code is reported with, typically CPT code 77263 *Therapeutic radiology treatment planning; complex,* the specialty society and RUC do not recommend any pre time. The specialty society indicated and the RUC recommends 5 minutes of physician post time for the physician to document the added planning and evaluation work and dictate a note. The specialty society clarified that the physician work includes the fusion of the PET CT with the simulation scan. The radiation therapist must go with the patient and immobilization device in order to obtain the PET CT scan. The radiation therapist does not do this at the same time as the physician work.

77470 *Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)*
The RUC reviewed the survey results from 126 radiation oncologists and recommends the following physician time components: pre-service time of 0 minutes, intra-service time of 50 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' work values and determined that the survey 25th percentile work value of 2.03 appropriately captures the work and complexity of this service. The RUC noted that it is not appropriate to compare the surveyed time to the current CMS/Other source time, which represents time, not derived from a survey, but assigned by CMS over 20 years ago. The RUC compared the service to key reference service CPT code 77307, *Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)* (work RVU = 2.90, intra time of 80 minutes) and noted that the reference code has more intra-service and total time compared to the surveyed code, justifying the greater work value. For additional support the RUC compared 77470 to 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.* (work RVU = 2.11, total time of 55 minutes) and noted that the reference code has identical total time and is slightly more intense to perform, justifying the greater work value. **The RUC recommends a work RVU of 2.03 for CPT code 77470.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs as submitted by the specialty society and approved by the Practice Expense Subcommittee.

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

Flow Cytometry Interpretation (Tab 42)
Jonathan Myles, MD (CAP); Jerry Hussong, MD (CAP); Ronald McLawhon, MD (CAP)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by

specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

CPT codes 88184 and 88185 are practice expense only codes as they represent the technical component of flow cytometry. Throughout the last decade, flow cytometric analysis has changed in that instead of just utilizing 3 and 4 color flow cytometry, most laboratories are now using 5, 6, 8, or even 10 color flow cytometry. The increase in the number of fluorochromes utilized makes the analysis more complex and each antibody and associated fluorochrome is typically analyzed (compared) to every other antibody/fluorochrome. This results in the need to compare many more antibody combinations for co-expression or mutually exclusive expression, which in turn increases the number of histograms to analyze. All of these changes have caused the services to be more intense and complex than the way it was performed previously. The specialty noted and the RUC agreed that when comparing these services to the surgical pathology services it is important to remember that 88187, 88188 and 88189 are bundled services with multiple markers. The surgical pathology services are not bundled and require more intra-service time but are less intense to perform. The surgical pathology codes are larger specimens requiring grossing which is less intense than microscopic work. The surveyed services do not require grossing and require highly cognitive and intense work. There is software necessary to analyze the data, but the software does not suggest a result or provide an interpretation.

88184 ***Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker***
88185 ***Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)***
CPT codes 88184 and 88185 were recently reviewed for practice expense (PE) only in April 2014. In the Final Rule for 2015 CMS refined those recommendations. Both the April 2014 RUC recommendation and the CMS refinements are listed on the PE spreadsheet. There is a third column on the spreadsheet that lists the specialty recommendation for this meeting. The specialty had originally recommended some increases over the RUC recommendations from 2014. The PE Subcommittee discussed all three sets of direct PE inputs and determined that it is appropriate to reaffirm the RUC recommendations from April 2014 with the following exceptions:

- supply direct PE inputs, *lysing reagent* (FACS) (SL089) increased from 2 to 3 ml for 88185 only
- supply direct PE inputs, *antibody, flow cytometry* (each test) (SL186) increased from 1 to 1.6 for both codes
- equipment direct PE inputs, *flow cytometry analytics software* was added for both codes

Because of changes in technology and increased interpretative sophistication, the PE Subcommittee greatly reduced the amount of lysing reagent, the driver of much of the cost of these services, in April 2014. The specialty explained and the PE Subcommittee agreed that it was appropriate to add 1 ml for 88185 only because the typical patient scenario requires 3 or more ml per marker plus a wastage allotment that is included in 88184. For 88184 the amount is reaffirmed at 3 ml for the first marker and 2 ml of wastage, making 5 ml necessary for 88184 only. For 88185 the amount recommended in 2014 of 2 ml is not adequate as each additional marker requires 3 ml, so the specialty recommendation of 3 ml was accepted. The PE Subcommittee also agreed that 1 antibody as approved in 2014 is not accurate as 1.6 antibodies are needed for each marker analyzed and reported. Although software is generally

considered indirect practice expense the RUC recommends the flow cytometry analytics software because it is necessary as multi-dimensional channel and marker interpretation and can be directly attributed to this service and not used for any other service. The RUC reviewed and approved the direct PE inputs as modified by the PE Subcommittee.

88187 ***Flow cytometry, interpretation; 2 to 8 markers***
The RUC reviewed the survey results from 83 pathologists and recommends 20 minutes of intra-service time. The RUC recognized significant time decreases since the RUC survey in 2004 and incorporated these time decreases into the recommendations.

The RUC reviewed the survey respondents' work values and agreed that the specialty societies' recommendation to crosswalk this service to recently reviewed CPT code 88346 *Immunofluorescence, per specimen; initial single antibody stain procedure is appropriate for this service* (work RVU = 0.74, intra-service time of 24 minutes) is appropriate for this service. The RUC compared the service to key reference service CPT code 88305 *Level IV - Surgical pathology, gross and microscopic examination...*(work RVU = 0.75, intra-service time of 25 minutes) and 88307 *Level V - Surgical pathology, gross and microscopic examination…*(work RVU = 1.59, intra-service time of 47 minutes). **The RUC recommends a work RVU of 0.74 for CPT code 88187.**

88188 ***Flow cytometry, interpretation; 9 to 15 markers***
The RUC reviewed the survey results from 82 pathologists and recommends 30 minutes of intra-service time. The RUC recognized significant time decreases since the RUC survey in 2004 and incorporated these time decreases into the recommendations.

The RUC reviewed the survey respondents' work values and determined that a work value of 1.40, the survey 25th percentile is appropriate for this service. The RUC compared the service to key reference service CPT code 88309, *Level VI - Surgical pathology, gross and microscopic examination…*(work RVU = 2.80, intra-service time of 90 minutes) and 88307 *Level V - Surgical pathology, gross and microscopic examination…*(work RVU = 1.59, intra-service time of 47 minutes), noting that the physician work and time is lower for the surveyed service. **The RUC recommends a work RVU of 1.40 for CPT code 88188.**

88189 ***Flow cytometry, interpretation; 16 or more markers***
The RUC reviewed the survey results from 91 pathologists and recommends 36 minutes of intra-service time. The RUC recognized significant time decreases since the RUC survey in 2004 and incorporated these time decreases into the recommendations.

The RUC reviewed the survey respondents' work values and determined that a work value of 1.70, the survey 25th percentile is appropriate for this service. The specialty explained that the utilization of this service has increased significantly since it was last reviewed by the RUC in 2004. This is because it is now the standard of care to classify acute leukemia by flow cytometry where previously it had not been. The RUC compared the service to key reference service CPT code 88309, *Level VI - Surgical pathology, gross and microscopic examination…*(work RVU = 2.80, intra-service time of 90 minutes) and 88307 *Level V - Surgical pathology, gross and microscopic examination…*(work RVU = 1.59, intra-service time of 47 minutes). **The RUC recommends a work RVU of 1.70 for CPT code 88189.**

Practice Expense
CPT codes 88187, 88188 and 88189 do not have direct practice expense inputs as they are professional component only services.

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

Microslide Consultation (Tab 43)
Jonathan Myles, MD (CAP); Swati Mehrotra, MD (ACS); Stephen Black-Schaffer, MD (CAP)

In the Final Rule for 2016 CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

88321 ***Consultation and report on referred slides prepared elsewhere***
The RUC reviewed the survey results from 52 pathologists and recommends the following physician time components: pre-service time of 0 minute, intra-service time of 50 minutes and immediate post-service time of 0 minute.

The RUC reviewed the survey respondents' estimated work values and agreed that the specialties' recommendation to maintain the current work value of 1.63 is appropriate for this service. The RUC compared the service to key reference service CPT code 88307, *Level V - Surgical pathology, gross and microscopic examination…* (work RVU = 1.59, intra-service time of 47 minutes) and noted that the surveyed service has slightly more intra-service time, justifying the slightly higher work value. For additional support the RUC compared the surveyed code to CPT code 99363 *Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)* (work RVU = 1.65, intra-service time of 50 minutes) and noted that the both services have similar intra-service time and intensity and should be valued similarly. **The RUC recommends a work RVU of 1.63 for CPT code 88321.**

88323 ***Consultation and report on referred material requiring preparation of slides***
The RUC reviewed the survey results from 43 pathologists and recommends the following physician time components: pre-service time of 0 minute, intra-service time of 60 minutes and immediate post-service time of 0 minute.

The RUC reviewed the survey respondents' estimated work values and agreed that the specialties' recommendation to maintain the current work value of 1.83 is appropriate for this service. The RUC compared the service to key reference service CPT code 88307, *Level V - Surgical pathology, gross and microscopic examination…* (work RVU = 1.59, intra-service time of 47 minutes) and noted that the surveyed service has more intra-service time, justifying the higher work value. For additional support the RUC compared the surveyed code to CPT code 92607 *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour* (work RVU = 1.85, intra-service time of 60 minutes) and noted that the both services have similar intra-service time and should be valued similarly. **The RUC recommends a work RVU of 1.83 for CPT code 88323.**

88325 ***Consultation, comprehensive, with review of records and specimens, with report on referred material***
The specialty explained that this is a low volume code that is only used when diagnosis is very difficult. The RUC reviewed the survey results from 39 pathologists and recommends the following physician time components: pre-service time of 0 minute, intra-service time of 90 minutes and immediate post-service time of 0 minute.

The specialty explained that there is compelling evidence that the technology has changed physician work, since this service was last reviewed in 2005. New technology or the more widespread use of some pathology testing has greatly increased the complexity and amount of materials available for review and interpretation to determine the diagnosis. Further, the consultation is generally for patients that may have been sent to many different pathologists and are difficult cases to diagnose. The RUC agreed that there is compelling evidence that the current work RVU for code 88325 is misvalued.

After consideration of the preliminary RUC reviewer comments, the specialty society revised their recommendation to the survey 50th percentile (work RVU= 2.85). The RUC agreed that a work RVU of 2.85 is appropriate for this code. The RUC compared the service to key reference service CPT code 88309 *Level VI - Surgical pathology, gross and microscopic examination…* (work RVU = 2.80, intra-service time of 90 minutes) and CPT code 88356 *Morphometric analysis; nerve* (work RVU = 2.80, intra-service time of 90 minutes) and noted that both services have the same intra-service time; however 88325 is slightly more intense to perform, justifying the slightly higher work value. For additional support the RUC compared the surveyed code to CPT code 90865 *Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview)* (work RVU = 2.84, intra-service time of 90 minutes). **The RUC recommends a work RVU of 2.85 for CPT code 88325.**

Practice Expense
The RUC reviewed and approved the practice expense inputs without modification as submitted by the specialty and approved by the PE Subcommittee. The PE Subcommittee noted that they reviewed the services with the understanding that slides are part of these consultation codes, however the vignette does not explicitly state this.

<u>Gastrointestinal Tract Imaging (Tab 44)</u>
R. Bruce Cameron, MD (ACG); Dawn L. Francis, MD (AGA); Shivan Mehta, MD (AGA); Seth A. Gross, MD (ASGE); Vivek Kaul, MD (ASGE)

In the Final Rule for 2016 CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 91110 was identified by this screen and CPT code 91111 was included as part of the family. These services were presented for review of physician work and practice expense at the January 2016 RUC meeting.

91110 ***Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report***
The RUC reviewed the survey results from 76 gastroenterologists and agreed with the following physician time components: pre-service time of 5 minutes (pre-time package 5 with

2 minutes removed from pre-service evaluation and 1 minute removed from scrub/dress/wait), intra-service time of 45 minutes and post-service time of 15 minutes.

The RUC reviewed the survey 25th percentile work RVU of 2.49 and agreed with the specialty society that this value appropriately accounts for the physician work required to perform this service. The RUC noted that the magnitude of reduction in work RVUs from 3.64 to 2.49 is justified when considering the corresponding reductions in intra-service and total physician time. The RUC compared the survey code to top key reference code 91112 *Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report* (work RVU=2.10, intra-service time of 40 minutes, total time of 60 minutes) and noted that the survey code requires more intra-service time (45 minutes vs. 40 minutes) and somewhat more work, supporting a higher value for the survey code. To further support a work RVU of 2.49, the RUC reviewed MPC code 99336 *Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate 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, 40 minutes are spent with the patient and/or family or caregiver* (work RVU= 2.46, intra-service time of 40 minutes, total time of 65) and noted that noted that the survey code requires more intra-service time (45 minutes vs. 40 minutes), identical intra-service time and a similar amount of physician work. **The RUC recommends a work RVU of 2.49 for CPT code 91110.**

91111 ***Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report***
The RUC reviewed the survey results from 34 gastroenterologists and agreed with the following physician time components: pre-service time of 5 minutes (pre-time package 5 with 2 minutes removed from pre-service evaluation and 1 minute removed from scrub/dress/wait), intra-service time of 18 minutes and post-service time of 15 minutes.

The RUC reviewed the survey 25th percentile physician work RVU of 1.50 and agreed with the specialty society that the current value of 1.00 is appropriate for this service. In addition, the specialty society stated that they did not believe there was compelling evidence to increase the existing value of this service. To justify a work RVU of 1.00, the RUC compared the survey code to MPC code 99238 *Hospital discharge day management; 30 minutes or less* (work RVU= 1.28, intra-service time of 20 minutes, total time of 38 minutes) and noted that both services have similar intra-service times, identical total times and involve a similar amount of physician work. The RUC also reviewed MPC code *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU= 1.01, intra-service time of 15 minutes, total time of 36 minutes) and noted that the survey code has more intra-service time and total time, further supporting a work RVU of 1.00 for the survey code. **The RUC recommends a work RVU of 1.00 for CPT code 91111.**

Practice Expense
For CPT codes 91110 and 91111 the clinical staff time on line 44 for *Other Clinical Activity: recharge batteries, initiate data download to workstation, create image archive* is distinct from the longer download time captured in the equipment minutes. This time is to start the data process and start downloading images into the workstation. For 91110, line 72, *video system, capsule endoscopy (software, computer, monitor, printer),* at 94 minutes includes a download time of 80 minutes. This is outlined in the Download Time for PillCam SB3

document included in the submission and it is the shortest download time for the video system needed for this service. Line 73, *kit, capsule endoscopy recorder* requires a recording time of 8 hours for the test plus 80 minutes download time. Typically, the patient comes in at 7am and returns at 4pm and multiple patients may return to the office at the same time. The video system (computer) has docking stations for multiple capsule recorders; however, the computer downloads the data from each capsule recorder in sequence because the equipment is not capable of downloading from multiple capsule recorders at the same time. For 91111, line 72, *video system, capsule endoscopy (software, computer, monitor, printer)*, at 29 minutes includes a download time of 15 minutes. This is the shortest download time for the video system needed for this service. It is the time that the capsule recorder is synced to the video system. For line 73, *kit, capsule endoscopy recorder*, there is no additional recording time because the patient remains in the office, however, 15 minutes of download time is necessary. The RUC approved the revised direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

Fundus Photography (Tab 45)
Stephen Kamenetzky, MD (AAO); David Glasser, MD (AAO); John Thompson, MD (ASRS); Charles Fitzpatrick, OD (AOA)

In the NPRM for 2016 CMS, re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 92250 was identified by this screen. This service was presented for review of physician work and practice expense at the January 2016 RUC meeting.

92250 ***Fundus photography with interpretation and report***
The RUC reviewed the survey results from 89 practicing ophthalmologists and optometrists and recommend the following physician time components: pre-service time of 1 minute, intra-service time of 10 minutes and immediate post-service time of 1 minute. The RUC agreed that there is only one minute of both pre- and post-service time because this procedure is typically done on the same date of service as an eye Evaluation and Management visit.

The RUC reviewed the survey respondents' physician work values and agreed that the survey 25th percentile work RVU of 0.40, lower than the current value, is appropriate. To justify a work RVU of 0.40, the RUC compared the surveyed code to the top two key reference codes 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU= 0.50, intra time= 10 minutes) and 92082 *Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)* (work RVU= 0.40, intra time= 8 minutes) and agreed that both these reference services, with similar intra-service time and comparable physician work, offer accurate comparisons to the recommended value. **The RUC recommends a work RVU of 0.40 for CPT code 92250.**

Practice Expense:
The RUC accepted the minor modifications as made and approved by the Practice Expense Subcommittee.

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

Electroretinography (Tab 46)
Michael X. Repka, MD, MBA (AAO); Stephen A Kamenetzky, MD (AAO)

In the NPRM for 2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 92275 was identified by this screen and to be reviewed at the January 2016 RUC meeting.

The specialty society noted that they became aware of inappropriate use of this code for a less intensive version of this test for diagnosis and indications that are not clinically proven and for which less expensive and less intensive tests already exist. The utilization of CPT code 99275 was appropriately low until 2013 when it suddenly increased by 300%. CPT changes are necessary to ensure that the service for which 92275 was intended is clearly described as well as an accurate vignette and work descriptor is developed. **The RUC recommends that CPT code 92275 be referred to the CPT Editorial Panel at the May 2016 meeting.**

Non-invasive Physiologic Studies of Extremity Veins (Tab 47)
Ezequiel Silva III, MD, FACR (ACR); Kurt A. Schoppe, MD (ACR); Matthew Sideman, MD (SVS)

In the NPRM for 2016 CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 93965 was identified by this screen. This service was presented for review of physician work and practice expense at the January 2016 RUC meeting.

The specialty societies explained that CPT code 93965 is a physiologic noninvasive vascular test, and the Introductory Comments in the Noninvasive Vascular Diagnostics portion of the CPT Manual clearly state that physiologic studies must be performed on instruments other than a duplex ultrasound scanner. Previously, this service could have been appropriately used in two ways. However, each indication is now obsolete. In the 2000s a test to detect lower extremity deep venous thrombosis employed an instrument called an Impedance Plethysmograph, or IPG. In the 2000s, IPG was replaced by a better test, duplex ultrasound (CPT code 93970). Additionally, duplex scanning has also replaced air plethysmography, which was previously used to test patients for chronic venous insufficiency.

Given the removal of these two indications, the specialty societies explained that they cannot identify a valid indication for the use of CPT code 93965. It is possible that clinicians are using the code to report the additional work of assessing venous valve function when duplex ultrasound is used to assess patients for chronic venous insufficiency. Under this scenario,

CPT codes 93970 and 93965 would be used in conjunction on the same date of service, which is the case 50% of the time, according to the Medicare 5% sample file. However, this coding practice is inappropriate if a duplex scanner is used exclusively to perform the test.

The RUC recommends that CPT code 93965 be referred to the CPT Editorial Panel for deletion. In accordance with this deletion, no current CPT code will be used to report this service. Furthermore, CMS should consider a payment policy which removes this service from active status and redistributes the savings for CY 2017.

Pulmonary Stress Test (Tab 48)
Alan Plummer, MD (ATS); Robert DeMarco, MD (ACCP)

In the NPRM for 2016 CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 94620 was identified by this screen.

The specialty societies explained that they have submitted a Code Change Application (CCA) for the February 2016 CPT Editorial Panel meeting. CPT codes 94620 and 94621 require revisions that will allow the survey respondents better value these services. Code 94620 describes two different tests commonly performed for evaluation of dyspnea, the six minute walk test as well as pre-exercise and post-exercise spirometry. These tests are entirely different and should be described with two separate codes. In addition, code 94620 describes a "simple" pulmonary exercise test and code 94621 a "complex" pulmonary exercise test. The testing described in 94621 is commonly called a cardiopulmonary exercise test (CPET) and not a complex pulmonary exercise test as it is currently labeled in CPT 2016. Code 94621 includes the measurement of minute ventilation and exhaled gases in addition to heart rate, oximetry and ECG monitoring. As such, it should not be included as part of the family of less complex exercise tests. The RUC will review these services at the April 2016 RUC meeting. **The RUC recommends CPT code 94620 is referred to the CPT Editorial Panel.**

Antigen Therapy Services (Tab 49)
Donald Aaronson, MD (ACAAI); James Sublett, MD (JCAAI); Paul Fass, MD (AAOA); Peter Manes, MD (AAO-HNS)

In the NPRM for 2016 CMS re-ran its screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 95165 was identified by this screen and code 95144 was included as part of the family. These services were presented for review of physician work and practice expense at the January 2016 RUC meeting.

Code 95165 is reimbursed on a "per dose" basis and code 95144 is reimbursed on each "single dose" vial prepared. Prior to conducting a survey, the specialty societies noted that the small increment of work and time related to a single dose in a multidose vial or single dose vial would be very difficult to capture on a survey and therefore the specialty societies requested from the Research Subcommittee to use a survey for work and time estimates related to 10 doses/vials. The survey responses would then be divided by 10 to reflect the per dose/vial increment.

95144 ***Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)***
The specialty societies indicated and the RUC agreed that the physician work related to code 95144 has not changed since the last RUC review. This was supported by the survey results from 46 allergists and otolaryngologists that resulted in no change in intra-service time (3 minutes). The RUC also reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work RVU of 0.06 per single dose vial, is appropriate and supports no change in work. To justify a work RVU of 0.06, the RUC reviewed other services with lower and higher work RVUs. The RUC agreed that 92285 *External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)* (work RVU= 0.05, intra time= 5 minutes) and 95905 *Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report* (work RVU= 0.05, intra time= 5 minutes) involved less intensive work to interpret a diagnostic study than 95144 which includes determining which antigens are to be used for therapeutic immunotherapy, the concentration for each antigen, the dosage schedule, and direct supervision for sterile preparation of single dose vials and quality control. The RUC also agreed that 96361 *Intravenous infusion, hydration; each additional hour* (work RVU= 0.09, intra time= 3 minutes) involves more intensive work for supervision and management of a patient than 99144. **The RUC recommends a work RVU of 0.06 for CPT code 95144.**

95165 ***Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)***
The specialty societies indicated and the RUC agreed that the physician work related to code 95165 has not changed since the last RUC review. This was supported by the survey results from 98 allergists and otolaryngologists that resulted in no change in intra-service time (3 minutes). The RUC also reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work RVU of 0.06 per single dose is appropriate and supports no change in work. To justify a work RVU of 0.06, the RUC reviewed other services with lower and higher work RVUs. The RUC agreed that 92285 *External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)* (work RVU= 0.05, intra time= 5 minutes) and 95905 *Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report* (work RVU= 0.05, intra time= 5 minutes) involved less intensive work to interpret a diagnostic study than 95165 which includes determining which antigens are to be used for therapeutic immunotherapy, the concentration for each antigen, the dosage schedule, and direct supervision for sterile preparation of multidose vials and quality control. The RUC also agreed that 96361 *Intravenous infusion, hydration; each additional hour* (work RVU= 0.09, intra time= 3 minutes) involves more intensive work for supervision and management of a patient than 99165. **The RUC recommends a work RVU of 0.06 for CPT code 95144.**

Practice Expense:
The specialty societies presented compelling evidence that the direct practice expense inputs have substantively changed since the previous valuation of these services. In 2007, the United States Pharmacopeia (USP), a national non-governmental standard setting organization, issued revised standards to its chapter 797 on sterile compounding that specifically addressed, for the first time, standards for preparation of allergen extracts. These standards became mandatory in 2013, with the passage of the Drug Quality and Security Act (DQSA) (P.L. 113-24).

The USP Ch. 797 sterile compounding standards applicable to allergen extracts require a number of staff activities which were not the standard in 2006 when this code was last reviewed. As a result, beginning in 2013 with the passage of the DQSA, clinical staff has had to change the way they prepare allergen extracts to meet the more stringent USP requirements. Some examples of ways in which staff have had to modify preparation technique include 1) more extensive hand-cleansing procedures; 2) use of hair covers, gowns, and face masks; 3) intermittent glove disinfection with sterile 70% isopropyl alcohol; and 4) more extensive disinfection of ampule necks and vial stoppers.

The RUC agreed that there is compelling evidence to increase both the clinical labor time and supplies associated with these procedures. The RUC approved the direct practice expense inputs as accepted by the Practice Expense Subcommittee.

Electroencephalogram (Tab 50)
Marianna Spanaki, MD, PhD (AAN); Marc Nuwer, MD, PhD (ACNS)

Following publication of the 2014 Final Rule, the RUC solicited feedback from the specialties societies regarding CPT codes potentially impacted by the OPPS/ASC Payment Cap. Specialty societies indicated an interested in re-reviewing or validating a recent RUC review for PE only, for 58 of the 211 codes identified through the cap. The PE Subcommittee reviewed the codes identified by specialty societies, grouped by families, at the April 2014 RUC meeting and provide CMS with the recommendations as a sample subset of the codes impacted by the cap. CPT codes 95812 and 95813 were included in these recommendations. CMS chose not to implement the RUC recommendations for 2015, but has reviewed and accepted the recommendations with refinement for 2016. CMS expressed concern about the way the services were selected for review and limiting the review to PE only. The RUC understands CMS' concerns about implementing PE inputs without the corresponding work being reviewed. We analyzed the 58 services that the RUC submitted PE recommendations for and determined that one or more of the following is true of many of the codes: frequency less than 10,000; reviewed for work within the last five years; included in the list of proposed potentially misvalued codes identified through high expenditure by specialty screen that CMS included in the proposed rule for 2016. If you apply these criteria only 6 codes remain. The codes are 10021, 30903, 88333, 88334, 95812 and 95813.

In the NPRM for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 95957 was identified by this screen. This service was presented for review of physician work and practice expense at the January 2016 RUC meeting.

95812 ***Electroencephalogram (EEG) extended monitoring; 41-60 minutes***
The RUC reviewed the survey results from 87 practicing neurologists and agreed with the following survey median physician time components: pre-service evaluation time of 5 minutes, intra-service time of 15 minutes and immediate post-service time of 5 minutes. The RUC discussed the inaccurate physician time currently assigned to the code (intra-service time= 55 minutes). The RUC noted that this past survey was conducted in May 1994 and appeared to, at the time, have significant issues. The CPT descriptor at the time for CPT code 95812 was *EEG monitoring; up to one hour*. It is clear from the survey time that the respondents were confused, as they assigned the entire monitoring time to physician work.

After the direct practice expenses became resource-based in 1999, this time discrepancy would not have been allowed. Therefore, the RUC agreed that the current physician time for this service is inaccurate and thus should not be used to discount the current work value.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's 25th percentile work RVU of 1.20 overestimates the physician work of this service. To determine an appropriate value, the RUC noted that there is no compelling evidence that the current value may be inaccurate and recommends the current work RVU of 1.08. To justify a work RVU of 1.08, the RUC compared the surveyed code to the top key reference code 95816 *Electroencephalogram (EEG); including recording awake and drowsy* (work RVU= 1.08, intra time= 15 minutes) and agreed that since both codes have identical intra-service time and comparable physician work, both services should be valued the same. The RUC also reviewed the second key reference code 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU= 1.20, intra time= 20 minutes) and that since the reference code has 5 additional minutes of intra-service time compared to code 95812, the reference code is accurately valued higher. **The RUC recommends a work RVU of 1.08 for CPT code 95812.**

95813 ***Electroencephalogram (EEG) extended monitoring; greater than 1 hour***
The RUC reviewed the survey results from 87 practicing neurologists and agreed with the following survey median physician time components: pre-service evaluation time of 5 minutes, intra-service time of 25 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's 25th percentile work RVU of 1.63, lower than the current value, is appropriate for this code. To justify a work RVU of 1.63, the RUC compared the surveyed code to MPC code 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU= 1.20, intra time= 20 minutes) and agreed that since code 95813 has more intra-service time, it is appropriately valued higher than the reference code. The RUC also reviewed CPT codes 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 time= 22.5) and 95908 *Nerve conduction studies; 3-4 studies* (work RVU= 1.25, intra time= 22 minutes) and agreed that since both these reference services have less intra-service time, the recommended value for 95813 is appropriately valued higher. **The RUC recommends a work RVU of 1.63 for CPT code 95813.**

95957 ***Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)***
The RUC reviewed the survey results from 54 practicing neurologists and agreed with the following survey median physician time components: pre-service evaluation time of 15 minutes, intra-service time of 30 minutes and immediate post-service time of 10 minutes. The RUC again noted the inaccurate current intra-service time of 60 minutes for this procedure. When this service was last reviewed in May 1994, this service was surveyed as an add-on code; however it was assigned a XXX global period when it was implemented in 1995. Therefore, the current time included pre- and post-service work and time in the intra-service period. Adjusting for these anomalies, the current survey, which separates these times out, represents only a minor reduction in total time. There exists no clinical basis to discount this minor reduction in time from the current work value.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's 25th percentile work RVU of 2.00 slightly overestimates the physician work of this service. To determine an appropriate value, the RUC noted that there is no compelling evidence that the current value may be inaccurate and recommends the current work RVU of 1.98. To justify a work RVU of 1.98, the RUC compared the surveyed code to the top two key reference codes 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU= 2.50, intra time= 36.5 minutes) and 95939 *Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs* (work RVU= 2.25, intra time= 30 minutes) and agreed that both services, with comparable physician time and work, provide accurate comparisons to ensure the recommended value is accurate. The RUC recommends a work RVU of 1.98 for CPT code 95957.

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

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

Electronic Analysis of Implanted Neurostimulator Pulse Generator System (Tab 51)
Kevin A. Kerber, MD (AAN); Marianna V. Spanaki, MD, PhD, MBA (AAN)

CPT codes 95971-95973 were recently reviewed for CY 2015. Due to significant time changes in the base codes, CMS requested that the entire family should be considered as potentially misvalued and reviewed in a manner consistent with review of CPT codes 95971, 95972 and 95973. The RUC added CPT codes 95970 and 95974-95982 to the list of potentially misvalued services to review based on the CMS request.

In January 2016, the specialty societies indicated they have actively worked with the CPT Assistant Editorial Board to alleviate incorrect reporting of these services, however, confusion remains giving the existing code language. The specialty societies indicated that they will revise the code language to more clearly define what is required for one of the parameters to be considered "changed" as well as correct the reporting of simple programming for cranial neurostimulators. **The RUC refers 95970 and 95974-95982 to the CPT Editorial Panel for revision.**

Psychological and Neuropsychological Testing (Tab 52)
Kevin A. Kerber, MD (AAN)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT codes 96101, 96116 and 96118 were identified as part of this screen.

CPT code 96116 had an interest from an MD/DO specialty society and was scheduled to be reviewed by the RUC. The remaining codes in this family had a non-MD interest and were scheduled to be reviewed by the HCPAC. In January 2016, the specialty societies requested

that the entire family of codes be referred to the CPT Editorial Panel to be revised. The testing practice has been significantly altered by the growth and availability of technology. The current codes do not reflect the multiple standards of practice and therefore result in confusion about how to report the codes. **The RUC recommends the entire psychological and neuropsychological testing codes be referred to the October 2016 CPT Editorial Panel meeting for revision. CMS also requested that CPT code 96125 and 96127 be added to this family of services for revision/review.**

X. Practice Expense Subcommittee (Tab 53)

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

- **Vital Signs Workgroup**
  At the last meeting a specialty society requested alternative vital signs be considered. The Subcommittee accepted the vital signs at that time and the question was raised, what are acceptable vital signs. A Workgroup was convened, chaired by Doctor Joel Brill. The Workgroup had one conference call and agreed that the seven vital signs listed in the report, which are the seven vital signs in the documentation guidelines for evaluation and management services, will continue to be our de facto standard and on an ad hoc basis we are happy to consider any other vital sign as may be appropriate for a given specialty as long as they can supplement with some literature and support. A specific example given was head circumference for the specialty of pediatrics or pain scales for a variety of different specialties.

- **Practice Expense Spreadsheet Update Workgroup**
  Another PE Subcommittee Workgroup is being chaired by Doctor Tye Ouzounian. This Workgroup is working to standardize templates so equipment minutes are automatically calculated and clinical labor activities can more easily and reliably be entered into the CMS database. The Workgroup has identified that there are unique aspects to radiation oncology and pathology services, so these clinical labor activities are being tabled. The Workgroup will develop nomenclature for the types of clinical staff activities that would be applied to the staff types. Currently the Workgroup is collating and identify those activities. After that work is done there will be discussion of the formatting of the spreadsheet.

- **Emergent Procedures Pre-Service Clinical Staff Time Review**
  Following review of codes identified by the Emergent Procedures Workgroup at the last meeting and the Pelvic Ring Fracture tab identified for review at this meeting, the PE Subcommittee developed a standard of 20 minutes of pre-service time in the facility for all services identified as emergent with the opportunity, as with other PE standards, for specialties to provide evidence in writing to justify that additional pre-service time is appropriate. This standard was applied to most of the codes identified as emergent; exceptions are explained in the report.

The RUC approved the Practice Expense Subcommittee Report.

XI. Relativity Assessment Workgroup (Tab 54)

Doctor Hitzeman informed the RUC that the Relativity Assessment Workgroup discussed five separate issues.

- **High Level E/M in Global Period Action Plans**
  Doctor Hitzeman indicated that this is a screen identified all services with Medicare utilization greater than 10,000 that have a level 4 (99214) or level 5 (99215) office visit included in the global period. There were no codes with volume greater than 10,000 that had level 5 visits. Nine services were identified that have a level 4 office visit. In October 2015, the Relativity Assessment Workgroup reviewed the data and requested action plans from the specialty societies for January 2016 to justify the 99214 office visit and review if the families of services that also have a level 4 visit for the following six codes: 15732, 15734, 44143, 64561, 64581, and 77427. **The Workgroup reviewed the action plans and recommended the following:**

CPT Code	Recommendation
15732 **15734** **15736 (f)** **15738 (f)**	The Workgroup identified that a 99214 office visit is included for 15732 and 15736 but not included in the other codes in this family. **The Workgroup recommends that the specialty societies survey the entire family for April 2016.**
44143 **44141 (f)** **44144 (f)** **44150 (f)** **44151 (f)** **44155 (f)** **44156 (f)** **44157 (f)** **44158 (f)** **44206 (f)** **44210 (f)** **44211 (f)** **44212 (f)**	The other colectomy codes that are part of this family appropriately include a 99214 visit. **The Workgroup requested that the specialty society thoroughly describe the physician work that justifies the 99214 visit and add this to the RUC rationale for future reference. The Workgroup recommends that the following description be added to the RUC rationale for this family of codes:** This set of 14 colectomy codes all result in the patient being discharged with an ostomy and all codes include one 99214 postoperative office visit. The specialties provided information to support the physician's work for this 99214 visit. This office time typically involves both the taking of a detailed history **or detail exam** and moderate complexity medical decision-making in an established **patient**. In addition, this visit typically takes 25-30 minutes and over 50% of the face-to-face time is involved with counseling of the patient and/or family, coordination of care, and/or pathology review. Both of these would support the 99214 Evaluation and Management service. This initial post-discharge office visit includes an extensive history taking that begins with a discussion about nutritional status, as well as the history of any potential post-operative complications. Most patients remain on an altered low residue diet during the early postoperative course and the diet will need to be reviewed and adjusted after discharge from the hospital. The surgeon will next evaluate the patient's wounds and remove sutures and/or staples as appropriate. The surgeon will remove the ostomy appliance to ensure appropriate healing of the cutaneous anastomosis, ensure there has been no separation of the intestine from the dermis, and check for adequate perfusion of the ostomy. It is common that the initial evaluation of the new stoma will require a provision of extensive psychological support for the patient regarding the new anatomy. Almost all patients in this situation remain shocked by this new anatomy and consider it a completely unacceptable option in proceeding with their life. Reiteration of inpatient teaching and ostomy care typically includes: when to empty the appliance, how to empty the appliance, the process of reapplication of the appliance and appropriate clothing bands and seatbelt placement. Since the presence of a wound, ostomy, and continence nurse is rare in the outpatient office, this is done by the operating surgeon. Moreover, it is generally necessary to re-

	evaluate the stoma appliance completely as the stoma commonly changes it's configuration as abdominal wall edema subsides. Materials available for stoma appliances are numerous and surprisingly complex. It may be necessary to alter appliance type and materials to ensure a good seal can be obtained to avoid leakage that can lead to skin breakdown and cellulitis. Evaluation of the skin around the stoma is necessary to identify this problem early and avoid this troublesome byproduct of poor stoma care. Many patients will immediately explore the options for reversal of the colostomy. This requires an extensive explanation of the healing process and an outline of the plan with the patient, his family, and the patient's primary care physician. Finally, it will be necessary to review the pathology of the specimen with the patient and determine if additional steps are necessary in care including changes in the treatment plan.
64561 **64581**	The Workgroup determined that the 99214 office visit is appropriate. **The Workgroup requested that the specialty society thoroughly describe the physician work that justifies the 99214 visit and add this to the RUC rationale for future reference. The Workgroup recommends that the following description be added to the RUC rationale for this family of codes:** A 99214 is an appropriate given the type of care provided in the post-operative visit. For these patients, criteria for the 99214 Evaluation and Management service are typically met in one of two ways. It involves at least 25 minutes of face-to-face discussion with more than 50% of that discussion involving counseling and coordination of care. In other instances, the 99214 requirements would be met by the detailed history (or detailed physical exam) with moderate complexity medical decision-making required for the care of these patients. At this post-operative visit, these patients require a detailed history to determine subjective and objective symptomatic response to the surgical procedure, a detailed review of the voiding diary, and detailed prescription management. Additionally, they require a moderately complex discussion about the decision to proceed with additional interventions. Additional details about this visit include examining the patient including wound check and checking vital signs, evaluating equipment function with specific neurologic examination, review of voiding diary and to evaluate for change in GI and GU symptoms, determine indications for next any future interventions, document the visit, update prescriptions, and communicate with referring physician.
77427	The Workgroup noted that the 3 visits (2-99213 and 1-99214) in the 6 weeks of following initiation of treatment were extensively discussed by the RUC when it was last reviewed and are appropriate. **Remove from screen**.

The RUC noted that no post-operative visits were removed so there were no consequences to the values or direct practice expense inputs. Additionally, this screen will be complete after these codes are reviewed as the RUC has more rigorously questioned level 4 office visits within a global period in recent years and will going forward.

- **High Volume Action Plans**
  Doctor Hitzeman noted that this screen identified all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013. The query resulted in the identification of 23 services. The Relativity Assessment Workgroup reviewed

these services and requested action plans for 9 of the codes identified to review for the January 2016 meeting explaining the high volume growth for these CPT codes. **The Workgroup recommends:**

CPT Code	Recommendation
17250	**Refer to CPT to revise the descriptor or include a parenthetical regarding appropriately reporting 17250 or 97597 and 97598. Refer to CPT Assistant to describe when to appropriately report 17250 or 97597 and 97598. The Workgroup should review utilization data and who is providing this service in October 2019.**
29445	The dominant provider has changed, there is high volume growth and it was surveyed more than 10 years ago. **Survey for April 2016.**
67028	Value was decreased in 2011. **Review utilization in 2 years.**
77014	This service is part of the radiation oncology code set held by CMS. **Currently referred to CPT for review, review utilization data after it is available.**
92507	Appropriate growth due to SLPs Medicare status change to report services independently. **Remove from screen.**
95831	**Notify CMS of inappropriate claims for this service in Texas by two providers, which account for 38% of the claims for this service driving the growth 106% in 5 years. Review 2016 and 2017 data when available (Fall 2018).**
95930	**Refer to CPT for May 2016 meeting to define a more specific delineation of test strategy relative to the clinical indication for the study. Specialty societies indicated they may recommend the elevation of Category III code 0333T to Category I as well.**
97532	Part of the CPT PM&R Workgroup under revision. **Remove from screen.**
G0250 **G0248 (f)** **G0249 (f)**	**Survey G0250 and review family of codes for April 2016.**

- **Emergent Procedures Action Plans**
  In October 2015, the Emergent Procedures Workgroup identified 34 services (closed treatment of fracture and CPT code 40650) that have 60 minutes of pre-service clinical staff time in the facility-only setting that involved issues beyond the emergent procedure issue. The Emergent Procedures Workgroup referred these issues to the RAW to review as potentially misvalued at the January 2016 meeting. Specialty societies submitted action plans addressing the appropriateness of site of service, global period, and dominant specialty for these services.

  Closed Treatment Fracture Codes
  The Workgroup had a robust discussion on these codes and determined that the 090 day global period is correct and an efficient bundling of the required services as well as share the same global period for all fracture care services. The Workgroup agreed with the specialty societies that the appropriate providers (emergency medicine and orthopaedic surgery) are reporting these services. The Workgroup noted that the emergency physicians are appropriately appending modifier -54. The specialty societies indicated that for these services that require anesthesia, it is unlikely that some of the specialties indicated in the Medicare utilization data actually perform the service under general anesthesia or regional block. **The Workgroup agreed and recommends that the specialty societies develop a CPT Assistant article to reinforce correct coding and modifier use for all fracture codes and guidance on the meaning of "requiring anesthesia" and "with anesthesia" as it relates to**

restorative fracture care. The CPT Assistant article should also address the issue of restorative care for closed treatment without manipulation.

40650 Repair lip, full thickness; vermilion only
The Workgroup reviewed CPT code 40650 and recommended that a CPT Assistant be developed to reinforce the correct use of modifier -54 for this service if performed by the emergency medicine physician.

The Workgroup determined that the Practice Expense Subcommittee are revising codes clinical staff time in the facility-only setting pre-time from 60 minutes and implementing a standard change to 20 minutes. **The Workgroup refers these 34 emergent procedure codes identified back to the PE Subcommittee to apply this new standard.**

The Workgroup noted that for these low volume services any additional aberrations will be identified in future screens if applicable and the Workgroup does not need to examine these services further at this time.

- **CPT 2013 Utilization Review**
  The Workgroup reviewed the work neutrality impacts for codes reviewed in the CPT 2013 cycle. There was one issue where there was a large growth in utilization in the first year. For CPT 2013 the Parathyroid Imaging codes were not work neutral, and it was initially estimated as a savings overall. It appears that there was 40% increase from what was projected.

  The specialty societies submitted an action plan indicating that literature supporting parathyroid scintigraphy as an effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services.

  The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be postponed and reviewed in 2 years after the CPT Assistant article is published.

- **CMS/Other G Codes**

  Physician Recertification/ Home Healthcare Supervision/Annual Wellness Visit (G0179, G0180, G0181, G0438 & G0439)
  In April 2013, these services were identified via the CMS/Other source codes. The Workgroup requested that the specialty societies submit an action plan for the January 2014 meeting. The Workgroup noted that G codes are developed for programmatic need and/or to address statutory requirements. The Workgroup noted that some of the G codes have Medicare utilization well over 1 million. The Workgroup reviewed all 10 G codes. The Workgroup recommended the following services be referred to CPT to possibly develop CPT Category I codes to define these services: G0101, G0179, G0180, G0181, G0283, G0438 and G0439. Codes G0202, G0204 and G0206 are being addressed with new CPT Category I codes at this January 2016 meeting and the RUC assumes CMS will delete the corresponding G codes for CY 2017.

For October 2015, AAFP and ACP submitted a letter indicating that creating Category I codes are not necessary as the G codes (G0179, G0180, G0181, G0438 & G0439) are working as intended and the creation of Category I codes would cause redundancy and overlap. The RAW reviewed this letter to determine if these codes should remain as referred to CPT to create a Category I code so a temporary G code may no longer be necessary.

The Workgroup reviewed this action plan and determined that the RAW should review the previous 10 G-code recommendations from the CMS/Other screen and determine where all these codes are at in the CPT process before determining a precedent and recommending that these G codes be surveyed.

At this meeting, the Workgroup reviewed the status of the 10 G-codes again:

- G0101 refer to CPT – will request the status from specialty society. If CPT proposal is not forthcoming, the Workgroup will consider next steps for this service at the April RAW meeting;
- G0283 is under review as part of the PM&R review workgroup at CPT;
- G0202, G0204 and G0206 (mammography) have been addressed by CPT and Category I codes are were reviewed at this meeting; and
- The specialty societies reiterated that the physician certification, home healthcare supervision and annual wellness visit codes, G0179, G0180, G0181, G0438 and G0439, are Medicare only services or statutorily mandated codes that are valued appropriately. The Workgroup noted that the RUC has surveyed and provided recommendations on G codes in the past. The Workgroup questioned how CMS valued these services. **The specialty societies did not have that information readily available, and therefore requests that AMA staff research how CMS valued these services and the Relativity Assessment will review in April 2016 to determine how to address these services.**

The RUC approved the Relativity Assessment Workgroup Report.

XII. Emerging CPT/RUC Issues Workgroup (Tab 55)

Doctor Raphaelson, Chair of the Joint CPT and RUC Emerging Issues Workgroup, provided the following report:

- **The Joint CPT and RUC Emerging Issues Workgroup reviewed its charge:**
  Workgroup Charge: (1) Continue work of the former chronic care coordination workgroup to identify coding/payment solutions for non-face-to-face services, including to responding to CMS rulemaking; (2) address specific RUC related questions related to advanced payment models as they arise; and (3) work with CPT to address any CMS proposals on BETOS and other potential coding/payment issues in rulemaking.

- **The Joint CPT and RUC Emerging Issues Workgroup reviewed CPT Proposals Under Consideration:**
  Nine CPT coding proposals are to be considered by the CPT Editorial Panel at the February 2016 meeting. The Workgroup discussed a number of these proposals in general terms.

  The Workgroup was informed that the specialty society intends to submit an entirely new coding proposal for Behavior Healthcare Management. It was noted that CMS specifically

supported the model discussed in this coding proposal in the July Proposed Rule. The proposal describes a team based care episode. Development and valuation of this code will impact future development of "episode" codes. The Workgroup also discussed the unusual complexity code proposal. This is similar to the interactive complexity psychiatry code.

Members of the Workgroup noted that new code proposals require CPT to consider modifications to some of its conventions and require RUC to consider modifications to survey methods. It was noted that any issues coming out of CPT that require specialized surveys or other methodological review can be addressed by the Research Subcommittee and can be addressed by the RUC at a future meeting. Due to the new cycle, the RUC does not have to conclude review by April.

- **The Joint CPT and RUC Emerging Issues Workgroup discussed next steps:**

  - The Workgroup had a general discussion regarding benefit of existing prolonged visit codes 99358 (Prolonged evaluation and management service before and/or after direct patient care; first hour) and 99359 (Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)) versus developing new codes that are more specific services (e.g. medication management). It was noted that 99358/99359 are not being covered/paid, and there was consensus that the medical community needs codes acceptable to CMS to describe non face to face work. The Workgroup would appreciate CMS feedback on why these codes are not covered, and will re-consider whether new codes may be needed.

  - The Workgroup consider a reasonable threshold of time in new non-face-to-face service. Services described in a new code should not be duplicative of pre/post time of E/M services, and allow CMS to be confident that they are used with integrity. It was suggested that a minimum of 30 minutes per month may be appropriate for new codes for non face to face services.

  - A Workgroup member requested a grid of all that CPT/RUC has completed to date and what CMS has implemented. This summary would include medical home and all non-face-to-face services. Staff noted that they would update the summary and share at the next meeting.

  - The Workgroup discussed future directions related to episode groups and APMs. Societies are expected to respond to a CMS RFI related to episode groupers mid-February, and CMS is expected to provide some direction in the July Proposed Rule regarding APMs. The Workgroup concluded that this is a long-term transition that requires CMS direction regarding future coding needs related to APMs.

  - The Workgroup expects that a number of future codes will involve work among teams of providers. The Workgroup recommends that RUC Research Committee summarize precedents when the survey instrument has been modified for similar circumstances and consider the need for future survey modifications for team care.

The RUC approved the Joint CPT and RUC Emerging Issues Workgroup Report.

XIII. HCPAC Review Board (Tab 56)

Jane White, PhD, RD, FADA, Co-Chair of the HCPAC, provided the following report of the HCPAC:

- **The HCPAC had introductory discussion on the following:**
  Doctor Edith Hambrick from CMS attended the HCPAC meeting. Doctor Hambrick provided a brief CMS update and stated that CMS is hosting a call-in on Collecting Data on Global Surgery as required by MACRA on Wednesday, January 20th. Dr. Dee Adams Nikjeh asked about the Manual Medical Review criteria for therapy spending cap for SL/P, PT & OT. No further information was available.

- **The HCPAC recommended the following:**

  Relative Value Recommendation for CPT 2017:

  Removal of Nail Plate (11730)

  The American Podiatric Medical Association (APMA) surveyed a CPT code (11730) identified by the CMS High Expenditure Procedure List.

  11730 ***Avulsion of nail plate, partial or complete, simple; single***
  The HCPAC reviewed the survey results from 54 podiatrists for CPT code 11730 and determined the proposed work RVU of 1.10 appropriately accounts for the work required to perform this service. The HCPAC recommends pre-service evaluation time of 10 minutes, pre-service positioning time of 3 minutes, pre-service scrub, dress, wait time of 5 minutes, intra-service time of 10 minutes and immediate post-service time of 5 minutes. The HCPAC discussed that 11730 is typically not reported with an E/M when it is not performed in a facility setting. The HCPAC queried what it is reported with and APMA stated that it is most commonly reported with CPT code 11732 *Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)* (work RVU= 0.44)add on. The HCPAC also discussed the Key Reference CPT Codes 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm*) (work RVU= 1.14)which included 7 minutes of pre-service time, 15 minutes of intra-service time, and 5 minutes of immediate post-service time and 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.97) which includes 3 minutes of pre-service time, 15 minutes of intra-service time, and 5 minutes of immediate post-service time. The presenters provided a brief summary of the discussion from PE including minor adjustments to the medical supplies and equipment list. The HCPAC determined the PE was appropriately crosswalked to CPT code 11750 (*Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;*). **The HCPAC recommends a work RVU of 1.10 for CPT code 11730.**

  Practice Expense
  The HCPAC recommends the direct practice expense inputs without modifications as approved by the Practice Expense Subcommittee.

Psychological and Neuropsychological Testing (96101, 96102, 96103, 96116, 96118, 96119, 96120)

The American Psychological Association (APA) and the American Academy of Neurology (AAN) recommended that these services be referred to CPT. The APA letter informed the HCPAC that the testing practices referred to in these codes have been significantly altered by the growth and availability of technology. CMS also requested that CPT code 96125 be added to this family of services for revision/review. **The HCPAC recommends referral to CPT.**

- **The HCPAC discussed the following other issues:**
  HCPAC members requested that an educational session be held at the April HCPAC meeting where staff would review the Reviewer Checklist. The group discussed that comments from members are very helpful to presenters and a calendar of timelines for the review process was shared. It was discussed that when the HCPAC has one tab, all members will serve as primary reviewers and if more than one tab is up for review, members will be split across the tabs as primary reviewers.

The RUC filed the HCPAC Report.

XIV. Research Subcommittee Report (Tab 57)

Doctor Leahy, Chair of the Research Subcommittee, provided the following report:

- **New Proposed Terms and Definitions for RUC Sampling Methodology (December 2015):**
  - **Simple Random Sample:** A randomly selected subset of a society's general US membership with available email addresses, excluding RUC members, alternate RUC members, HCPAC members, alternate HCPAC members, students, post-graduate trainees and retirees. Each individual in the subset is chosen randomly, such that each individual has the same probability of being chosen. The use of this sampling methodology does not require approval from the Research Subcommittee.

  - **Random Sample of Applicable Subset(s):** Sampling from one or more subsets of a society's US membership with available email addresses based on certain subset characteristics, excluding RUC members, alternate RUC members, HCPAC members, alternate HCPAC members, students, post-graduate trainees and retirees. The goal of this methodology is to distribute surveys to those members of a society that are most likely to be familiar with or have experience performing the service under review. A random sample from each applicable subset, where each individual in the subset has the same probability of being chosen, should be taken. Whenever using multiple subsets, the Advisory Committee should endeavor to make the proportion of each subset analogous to the estimated demographics of the providers performing the service under review.

    Subset characteristics of the specialty society that do not require Research Subcommittee approval are:
    - Subspecialty certification or designation
    - Member has indicated experience with a certain modality, body region or diagnoses
    - Inclusion in an established specialty society member section

When using this sampling methodology, clearly explain how the sample was derived on the RUC Summary of Recommendations form under *Description of Sample*.

- **Targeted Sample:** Any sampling method which falls outside the definition of a Simple Random Sample or a Random Sample of Applicable Subset. The goal of this methodology is to distribute surveys to those members of a society that are most likely to be familiar with or have experience performing the service under review. Any list provided by industry is classified as a targeted sample. RUC members, alternate RUC members, HCPAC members, alternate HCPAC members, students, post-graduate trainees and retirees should be excluded. All targeted samples much be approved by the Research Subcommittee. When using this sampling methodology, clearly explain how the sample was derived on the RUC Summary of Recommendations form under *Description of Sample*.

The RUC approved the terms and definitions for RUC sampling methodology

- The Research Subcommittee agreed that the draft script and power point will need to undergo further Subcommittee review at the April 2016 meeting prior to the Subcommittee makes a recommendation on implementation. The Research Subcommittee requested for AMA staff to incorporate the suggestions made on the Webinar in the next draft and also to solicit specialty staff for additional recommendations.

- As an alternative to the "do you do or are you familiar with" letter, the Research Subcommittee discussed updating the approved survey cover memo language and survey instrument introductory text to state that only those that have experience performing the service(s) or that are familiar with the service(s) should complete the survey. The Research Subcommittee requested for AMA staff to draft updated survey memo and survey instrument language to indicate that the potential survey respondent should only complete surveys for services where they have either experience performing the service or where they are familiar with the service.

The RUC approved the Research Subcommittee Workgroup Report.

XV. Time/Intensity Workgroup Report (Tab 58)

Doctor Collins, Chair of the Time/Intensity Workgroup, provided the following report:

- **Review of Summary Data on the Current RUC Survey Intensity/Complexity Measures**
AMA staff conducted analyses comparing the previous intensity/complexity methodology to the current methodology. AMA staff gave a brief overview of the analysis noting the central finding was that, for the overall intensity/complexity question, the survey code was rated as more intense than the reference code 88.6% of the time. For the old intensity/complexity measures, this was the case for 79.4% of the time (for the previous intra-service intensity/complexity question). The Workgroup noted that in order to measure intensity accurately, there would need to be a way to determine the typical physician that performs the work for each service, taking into account experience, training, physical stamina, etc.

- **Code Families with Identical Times but different values (intensities)**
The Workgroup will review and discuss research papers on physician work intensity analyses by two current RUC members. Also, the Chair requested for AMA staff to perform an

analysis of IWPUT and other RVU distribution analyses across the Medicare payment schedule.

As first proposed at the October Workgroup meeting, the Workgroup could explore expanding the basic analyses of survey time data or incorporating more advanced statistical measures. At the December meeting, Workgroup members provided a range of ideas focusing on different ways of examining the distribution of data. Workgroup members suggested further consideration should be given to variance, standard deviation and histograms. The Workgroup will likely piloting some surveys were histograms of time data are presented. That is still under discussion.

Another area of discussion is that survey respondents often appear to round time estimates to the nearest multiple of 5 minutes. Several Workgroup members concurred with this observation with some noting that, for very long procedures, those respondents appear to round to the closest 15 minutes. AMA staff will draft potential language for the Workgroup to consider at its next meeting in April 2016.

- **Discussion: Intra-service Work Per Unit of Time (IWPUT) Usage and Calculation** There is concern with the current usage of the IWPUT formula, because old codes sometimes have an anomalous IWPUT or even a negative IWPUT.

The RUC approved the Time/Intensity Workgroup Report.

XVI. Surgical Global Workgroup (Tab 59)

Doctor George Williams, Chair, provided a summary of the Surgical Global Workgroup report:

- Recently CMS announced that they would be holding an open forum call on January 20th entitled *Collecting Data on Global Surgery as Required by MACRA Listening Session*. The purpose of this call is to solicit comments so that RAND, which has been hired by CMS to construct the Agency's collection process, can hear feedback from the physician community on the legislative mandate the Agency has to collect data related to the work performed in the post-operative period of surgical services.

- CMS posted five questions and they are seeking input on and the Workgroup had discussion surrounding each one. Doctor Williams summarized the main discussion points.
  - The Workgroup again reiterated that the preferred method for collecting this information is the use of CPT code 99024 *Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure* is currently being reported in many large hospital-based physician group practices, and in other employed practices using facility based billing.
  - To collect the level of visits, while the Workgroup advised CMS to refrain from this task, due to the unlikelihood that the current data is inaccurate, the Workgroup offered two collection methods. First, the Agency could a modified survey, which could be completed by the representative sample that would indicate what level of visit they performed for the typical patient for a given service. Second, CMS could create a separate portal that could collect this information.
  - The Workgroup also reiterated that the Agency should not use a claims-based collection mechanism to determine the additional physician work and practice expense involved in

the global period. The current direct practice expense inputs are extremely granular and have the advantage of having direct Agency participation at the RUC. Again, the Agency should consider the above mechanisms described above (e.g. modified survey and/or a separate portal) to collect this information.

- The Workgroup also noted that the RUC is in a position to review the Medicare data to determine a set of services which are representative to the spectrum of specialties who perform surgical services. AMA staff can array the surgical services by total specialty volume, the number of surgeons performing the service and allowed charges.

- After the report was given, a member of the Workgroup noted that there was discussion around the issue of incident-to and it should be reflected in the report. Therefore, the following language was added to the final report:
  - Additionally, several Workgroup members suggested that the issue of incident-to be considered. The members were specifically concerned that data on who performs the post-operative visits be collected. Specifically, is it a physician or a physician extender?

The RUC approved the Surgical Global Report, as modified at the table.

XVII. Other Business (Tab 60)

- A RUC member brought up the issue that at this meeting as has happened at other meetings, it appears that CPT is getting different information than the RUC gets. Doctor Bothe from CPT clarified that there were recently questions added to the CCP that do address this issue. Staff will update the reviewers' checklist to ask the reviewer to look at the CCP to ensure that utilization data is consistent with information provided to the RUC. Research Subcommittee also looks at this when asked for targeted survey.

The RUC adjourned at 5:45pm

AMA/Specialty Society RVS Update Committee **Tab 26**
Practice Expense Subcommittee
January 29, 2015

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	Immunofluroescent 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 **Tab 27**
Administrative Subcommittee Report
January 29, 2015

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	

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.**

AMA/Specialty Society RVS Update Committee **Tab 28**
Health Care Professionals Advisory Committee Review Board
January 29, 2015

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 6th.

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 in 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.

AMA/Specialty Society RVS Update Committee **Tab 29**
Relativity Assessment Workgroup
January 29, 2015

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.

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

AMA/Specialty Society RVS Update Committee **Tab 30**
Research Subcommittee Meeting
January 29, 2015

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 IWPUT 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.

AMA/Specialty Society RVS Update Committee **Tab 09**
Genitourinary Catheter Procedures
Facilitation Committee #1

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 refereed 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 **Tab 10**
Facilitation Committee #2
Tab 10 - Penile Trauma Repair

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 25th 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 5543X2: 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 intrastromal 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.